University of Alberta

High Lives/Low Lives: Women's Narratives of Drug Addiction

by

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A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in English

Department of English and Film Studies

Edmonton, Alberta
Fall 2007

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Direction du
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395, rue Wellington
Ottawa ON K1A 0N4
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Your file Votre référence
ISBN: 978-0-494-33035-7
Our file Notre référence
ISBN: 978-0-494-33035-7

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Abstract

High Lives/Low Lives: Women's Narratives of Drug Addiction addresses the recurrent cultural erasure of white, middle-class women's illicit drug use through reading the life stories that female addicts and recovering addicts produce at moments when *the figure of the white, middle-class female addict* becomes particularly visible. Mapping the historical and social circumstances of women's stories of addiction, each chapter reveals patterns of social change that render the white, middle-class female addict visible. I argue that when these women become visible as drug addicts, they engage with popular medicalized discourses of addiction to construct life stories that earn them cultural audibility, authority, and redemption. Chapter One explores the first published voice of drug-addicted women in American literature, O.W's *No Bed of Roses: The Diary of a Lost Soul* (1930). Focusing on the treatment that O.W. receives at the hands of emergent addiction specialists in the early 1920s, I argue that O.W. embodies the paradigmatically paradoxical conception of the white, middle-class female addict as innocently ill, inherently deviant, and intentionally criminal. Chapter Two explores Martha Morrison's struggle to accept her addiction as a "disease" over which she has no control in her twelve-step autobiography, *White Rabbit: A Doctor's Own Story of Addiction, Survival, and Recovery* (1989). *White Rabbit* reveals the disease concept as mechanism by which middle-class privilege and heteronormativity are maintained. Chapter Three examines Susan Gordon Lydon's use of the 1980s and 90s feminist reconceptualization of psychological trauma to construct her drug addiction as a symptom of her traumatic past *in Take the Long Way Home: Memoirs of a Survivor*

(1993); I evaluate the effectiveness of trauma as a feminist framework for representing women's addiction. Chapter Four analyzes two 2005 *Oprah* shows, "Will She Choose Life or Death? An Oprah Show Intervention," and the follow-up, "The 17-year-old Meth Addict: Did She Quit?" *Oprah*'s therapeutic discourse relies on the current prevalence of pathology as a norm and reinscribes addicted women as blamelessly "sick." White, middle-class addicted women face a cultural imperative to tell their stories in exchange for therapeutic "help" and cultural redemption. I ask, what must they say to be heard?

A Personal Preface
(2003)

On many occasions during my PhD program, I have been asked to explain my motivation for studying women's autobiographical accounts of their lives as illicit drug addicts. I recognize the importance of being able to articulate, in academic terms, a motivation for my research. Fundamentally, my research is motivated by a political commitment to examining and understanding the society we inhabit. Given the centrality of gender to the organization and operation of our society, studying women – their roles and representations, their voices and silences – yields insights about society and how we might bring about change. My research is motivated by a feminist politics that assumes the cultural importance of women's writing. Drug-addicted women tell emotionally resonant stories that negotiate the complexities of the discourses of addiction. Simultaneously marginalized and privileged, white, middle-class drug-addicted women in particular construct and navigate contradictory subjectivities within the compulsory institutional disciplines of drug addiction – medicine and the law. This is my brief academic response to the queries about my motivation for studying women's writings on their experiences of drug addiction. (I take up these motivations differently in my discussion of my methodology in my Introduction). Most of the time, when I give this response or something like it, I get the sense that this is not what people want to hear. Some other kind of response is anticipated, some personal story that will account for my interest in drug addiction, something that connects me intimately with the women whose lives I read.

Sitting in my supervisor's office one afternoon, discussing why the focus of my project was shifting from the rhetoric of drugs to women's experiences of drug addiction and what my motivation might be for undertaking a project on women's first-person accounts of their lives as illicit drug addicts, my supervisor asked me, "Do you enjoy illicit pleasures?" My only response, if I recall correctly, was to laugh uneasily. I remember wondering what it was exactly that she expected to hear in response to such a question. How was this direct inquiry about my personal preferences supposed to get me any closer to a working thesis for my dissertation? Moreover, how would I be judged – as an academic, as a person, as a woman – if I responded honestly? How would my work be judged? If I responded with an enthusiastic affirmation – "absolutely, I love 'illicit pleasures,' I partake of them whenever I can" – would I risk losing credibility as an intellectual and respect as a person? Or, if my response were a more subtle acknowledgement – "yes, from time to time, I have been known to 'enjoy illicit pleasures'" – would my project be validated by the suggestion of my experience? If I denied my involvement with "illicit pleasures" of any kind, how would I account for my interest in (and knowledge of) drugs, one of our culture's most popular "illicit pleasures?"

Another time, a professor, whom I had not formally met until this moment, approached me outside our designated meeting room and eagerly inquired, "Are you a recovering drug addict?" I believe my immediate response was to blink incredulously. Met with my obvious hesitation to respond, she retracted the question with a quick dismissive gesture and reworded it as something less specific and personal, something like, "how did you come up with this project?" I mumbled something vague about the disturbing consequences of the rhetoric of drug addiction in the lives of real people. I added that I had known a few people who took drugs habitually and that the project came out of the realizations I had about drug addiction through my experiences with them.

Again, I wondered what it was that this professor expected to hear. And, again, I wondered about these inquiries that not only demanded me to position myself in such close relation to the material I study, but assumed that I could in fact do so. Was there an assumption that my experiences would lend a kind of authority and credibility to the project that would be impossible (or at least very different) if I did not have first-hand experience with drug addiction? Or were people wanting some explanation of my emotional investment in the project? And why was I so hesitant to respond to both questions when I had in my mind immediate answers? If I were studying, let's say, representations of single women in Victorian literature, would I be subject to the same kind of personal questions? Was I being paranoid imagining that power relations were at least part of what was at stake in my responses to these questions?

I do not mean to suggest that I expect to be morally and intellectually judged solely on the basis of my responses to the questions posed by these professors. And, for the record, fellow PhD students have asked me very similar questions also with the assumption that my experiences intimately inform my work. The anecdotes I recount here are some of my more vivid memories of conversations about my dissertation. They are meant to illustrate some of the challenges of positioning myself in and to my study of women's narratives of drug addiction. To me, the anecdotes raise important questions about the politics of identifying as a "drug user" (or "non drug user") or a "recovering drug addict" in a culture that continues to stigmatize illicit drug use, especially by women, despite dominant rhetoric that claims that addiction is a disease over which its victims have little or no control. Moreover, these anecdotes reflect a cultural imperative, demanded of drug addicts, especially female drug addicts, to construct and to tell an autobiographical story of their addiction. I am concerned with this cultural imperative to reveal oneself, to produce an autobiography. Part of what this dissertation examines is the assumptions and conditions that produce this imperative.

These anecdotes also remind me that my reader will have similar questions about my relation to this project, and, somehow, I have to address this question of motivation. The autobiographical narrative that follows is an attempt to begin to explain my reasons for undertaking this project. In it I offer more or less honest answers to the questions posed by my professors. I remain cautiously self-revelatory here. I worry that these personal revelations may be interpreted as confessional. But, I do not write with the assumption that I have done something worth confessing. These are not my guilty secrets and I do not seek redemption. I offer here some of my earliest memories of my thoughts about and encounters with drugs in the hopes that they go some way towards explaining my investment in this study of women's writings on their experiences of drug addiction.

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When I began thinking about this project, I envisioned it as a study of the rhetoric of drugs in contemporary North American culture. I grew up, or at least came into some kind of cultural consciousness, during the 1980s, a time of marked American drug panic and the Reagan administration's anti-drug media campaign, the
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images of which suffused my daily life as a junior high school student in suburban Southern Ontario. I remember quite vividly watching the now often parodied fried egg anti-drug public service announcement (PSA) on television: the close-up shot of a frying pan, the egg cracking and oozing onto the hot pan with an astounding sizzle, and an ominous masculine voice informing me that this frying egg was in fact "my brain on drugs" rather than an integral part of the Sunday brunch I imagined it to be. I don't recall any teachers actually discussing drugs or drug use with us, although there may have been the occasional school assembly on the subject, which I most likely used as an opportunity to socialize or to get some fresh air. But I do remember seeing posters replicating the fried egg PSA, and I certainly remember hearing and seeing Nancy Reagan's "Just Say No" slogan over and over and over again: "Just Say No" bumper stickers, "Just Say No" posters, "Just Say No" radio spots, "Just Say No" television announcements, "Just Say No" print ads in my teen celebrity magazines. To my thirteen-year-old mind, the preponderance of this anti-drug axiom, along with the fried egg, seemed a little suspect. Like many teenagers, I began to develop a healthy skepticism of authority as well as a curiosity about drugs, these bad but ambiguous things that so many people so emphatically warned me against in the most obscure terms.

Thinking back, I now realize that I had no idea what drugs were. I had a vague notion that one of the long-haired, leather jacket-clad older guys, who hung out in the school parking lot behind one of the portable classrooms, might one day offer me something to which I should "Just Say No," but what that something would be exactly, I had no idea. A pill, a joint, a line, a tab, a toke, a toot, a shot – none of these means of ingestion were part of my vocabulary or my imagination.

Learning about drugs through the Reagan media campaign, I thought of drugs without any sense of differentiation between substances or their effects.

What I did know, however, was that an awful lot of people were going to great lengths to convince me that drugs – whatever they were – were something bad that bad people did, and, moreover, that these bad drug people were very persuasive and committed to making innocent young people, like me, take drugs. Despite the obvious melodrama of the fried egg spot, I also learned and believed that drugs – of any kind, in any dosage, under any circumstance – would simply fry my brain and quite possibly kill me. I knew that I didn't want a fried brain, but I also had a vague notion that drugs would make me trip – feel good and see cool things. Although I don't recall precisely where I picked up this bit of jargonish information, I now recognize that the Reagan anti-drug campaign spoke against many cultural voices that represented drugs and drug use as exciting, sexy, and just outright cool, in an ever-important counterculture kind of way. (Of course, it sought to silence other voices still that called for drug education and decriminalization in the face of rising drug use among the middle and upper classes).

I also remember observing that the noted and rumoured "druggies" in our high school were all boys. I had no desire to belong to or to impress this group of boys, but I also had little desire to belong to the cliques of girls my own age. I think, although it is easy to imagine this now, that I recognized drugs as a masculine domain, a realm that, were I to be a part of it, would not just signify but proclaim and embrace my outsider status. Amid early teenage rebellion, insecurity, a sense of alienation, and a myriad of other cultural and personal circumstances, the countercultural message and the excitement of all the badness of drugs appealed to me immensely. But the fried brain message stuck, and, while I still had my suspicions that these anti-drug rhetoricians were full of crap, they managed to instill in me a fear of drugs potent enough to keep me at observer status for the duration of high school and my undergraduate degree. (I drank a lot from age 14 to about 25, but, according to my research, that's another story).

Without turning these autobiographical introductory remarks into confession, I'll say this: things changed. My curiosity about drugs remained fairly constant, and I've often speculated that were I born and raised in an urban environment, were I born into a class less privileged than middle-class, which promised me economic security and every educational opportunity I cared to imagine, were I born an ethnicity other than white, were I not inundated with anti-drug rhetoric during my adolescence, my relationship with drugs would have been much more intimate and perhaps more destructive much earlier. During a time of tremendous stress, insecurity, and change in my life, I developed a close but troubled relationship with a man who had an immense repertoire of drug experience and was willing to share some of his expertise.[1] And it was expertise. Before every new drug I tried with him, he dispensed an appropriate dosage, told me what kind of reaction to expect, and taught me how the drug worked chemically to produce this response in my brain. I felt like an intelligent, educated, and responsible drug-user.

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[1] Women are often introduced to drugs by a man with whom they are or become romantically involved. In the stories that I read in this project, "meeting a man" is a kind of narrative convention, a cue that an introduction to drug use or further involvement in the "life of drugs" will follow. My introduction to drugs reads like many other women's stories of drug initiation.

Having long ago disregarded the moral judgments and arguments I learned early in my life about drugs and their users, I felt no guilt or shame about my drug use. I was aware, however, that not everyone shared my "open-mindedness," and I attempted to keep my drug use hidden from my parents and colleagues. When I began to recount my experiences to the couple of close friends I still had from high school, I encountered significant censure. Their responses to my drug use were, to my mind, startlingly judgmental and clichéd. Taking up the rhetoric of the 1980s without any sense of parody, one of my friends advised me with reproach, "friends don't let friends do drugs." The same friend also informed me that the drug I was beginning to use with some regularity and distinct purpose was a "white trash" drug, popular with America's so-called trailer population, according to an article she had read in *Time*. I suppose this reference to the relationship between the drug and ethnicity and class was meant to be a deterrent to my use, but I easily dismissed the remark as irrelevant. After all, my identity was not entirely contingent on this or any other drug. My friends' attempts at dissuasion went unheeded, and I felt further ostracized and misunderstood.

It is easy for me now, with hindsight, as well as years of research on the rhetoric of drugs and narratives of women's drug addiction, to see how my personal circumstances and self-perceptions contributed to my pursuit of drugs. Moreover, given that a significant part of my research is concerned with the narrative reconstruction of women's experiences of illicit drug addiction, it is also easy for me to recognize that I am able to arrange memories of certain behaviours and thoughts into what, for me, has become a conventional drug narrative. While my story does not include homelessness or prostitution as the consequences of illicit drug use and addiction, as many women's stories do, and while my story does not end in successful recovery (none was needed), I identify with a kind of narrative of causation with which many women's stories of addiction begin. I recognize myself in former female drug addicts' descriptions of depression, in the sketches of their lives as filled with sadness, hopelessness, and seemingly inexplicable self-hatred, feelings that prompt a desperate search for relief and a subsequent turn to drugs. The details of my life at the time that I started using drugs regularly are in some ways befitting of a typical narrative of causation. I was depressed the majority of the time. I barely had time to sleep or cook proper meals. I had no money. I was overwhelmed by the work I was trying to do. I'd just left an unfulfilling three-year relationship in which I gained almost thirty pounds. I was preparing to move across the country and leave my family and friends. Despite being accepted to the PhD program here at the University of Alberta, I felt stupid and insecure. I was full of self-loathing, the roots of which perhaps stretched predictably back to childhood. I did not consciously seek relief from any of these circumstances or feelings; I simply sought the company of someone who understood what it felt like to live this way. Then, I sought to erase myself. Of course, this is the story I tell now. Then, I was learning something different.

As the relationship with my drug mentor progressed, I discovered not how much pain *I* was in, but how much pain *he* was in. Abused routinely by a parental figure as a child, he suffered debilitating feelings of worthlessness and self-hatred. On several occasions, I had to rouse him back to consciousness; but drugs, he told me more than once, saved his life. The more time we spent together, the more it became apparent that he needed this life preserver every waking moment. For the first time, I realized that drug use and addiction had a lot more to do with people's pain and everyday trauma than they had to do with counterculture or moral weakness or the physiological and neurological effects of substances deemed addictive drugs. This realization may not seem momentous to many, but to me, an admittedly naive and un-self-reflexive twenty-three year-old, it was epiphanic. As trite as it sounds, I realized that drug addiction had nothing to do with "right or wrong," and that the agency ascribed to drugs was a ruse constructed to deter people from asking questions that would lead to disturbing answers about the causes of drug addictions. The judgment and ignorance of my long-time friends and the moralistic anti-drug rhetoric I had learned as an adolescent irritated and saddened me. The rhetoric of drug use and addiction and the dismissal of people as "addicts" or "junkies" seemed unjust and culturally treacherous. And so, I began to articulate this project.

Acknowledgements

I have been fortunate to have many bright, generous and incredibly patient people around me during the writing of this dissertation.

Foremost, I would like to thank my supervisor, Daphne Read for her calm, steady support, "illicit" questions, and continued incitements to "keep writing." I am grateful to Mark Simpson for his unique critical insights and remarkably incisive questions, which repeatedly transformed my thinking. Dianne Chisholm's enthusiasm for this project has inspired me since the beginning. In the final stages, Erika Dyck and Caroline Acker provided thoughtful, provocative comments and questions. My research was also supported by a Social Science and Humanities Research Council of Canada Doctoral Fellowship.

I am also lucky to have such fantastic friends to thank. Without the encouragement and unwavering support of Melisa Brittain, Marino Eliopoulos, Gaby Zezulka-Mailloux, Karen Engle, and Mebbie Bell, I would have undoubtedly succumbed long ago to the voices of self-doubt. I'd also like to thank Renèe Wingrave for facilitating my matcha habit, letting me treat Steeps like my personal office, and knowing when I needed an ear. Thanks to my colleagues in the dissertation writing group (GTFO, 2005-2006. Better late than never). Cole, David, and Brea taught me how to exhale, for which I am eternally grateful. And I must also thank Tim Knutton, who, despite my many protests, managed to convince me that life and love were possible even in the midst of a tumultuous affair with my dissertation. I have much gratitude and admiration for his vast reserves of patience, compassion and silliness.

Finally, my parents have been a constant source of emotional and material support throughout my extended tenure as a grad student. Their untiring love, encouragement, and faith has sustained me. I am grateful to them also for instilling in me a desire to learn. Without them, I could not have done this.

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Introduction

> The psychology of the drug addict is the psychology of the average human being. It is the psychology of you and me when in pain, of you and me when desiring relief, of you and me when either of us finds himself incapacitated and quite innocently in a situation he has been taught to believe is degrading. It is the psychology of self-defense, of self-protection, and it is the psychology arising from persecution, intolerance and ignorance. It is the psychology engendered by the attitude of the man who has not suffered and who, without imaginative faculties or scientific knowledge, tries to explain the mental state of others. It is the psychology of the fear of death in one who knows what will avert his end. It is no less natural, this mental state, no more morbid than the psychology which prompts a thirsty man to drink, a hungry man to eat, a ravished woman to defend herself, an oppressed people to wage war.
> -- Charles E. Terry, "Some Recent Experiments in Narcotic Control," *American Journal of Public Health* (1921)

I have been captivated by this passage since I first encountered it almost five years ago while researching early-twentieth-century drug addiction treatment protocols as preparation for writing about *No Bed of Roses* (1930), the first drug memoir written by a woman. American physician Charles E. Terry penned these eloquent words in 1921 in response to the rapid and thorough demonization of "the drug addict" as a degenerate criminal by a government administration that, in the preceding couple of years, enacted unprecedented control over the supply of opiates and physicians' prescription practices. Terry also takes aim at the nascent discipline of psychiatry, which postulated psychopathology as the basis of drug addiction, and thus constructed the drug addict as an inevitably immoral and hopeless menace to society. Terry's outright dismissal of the popular notion of a distinct psychopathology of drug addiction, and his assertion that "the psychology of the drug addict is the psychology of the average human being" undoubtedly aroused indignation among 1920s social reformers and anti-drug campaigners, and portions of the quickly expanding medical profession.

What initially struck me about this passage, however, was Terry's empathy for the drug addict. I imagined "war-on-drugs" zealots of the 1980s responding as vehemently to Terry's descriptions of the addict as Progressive reformers had some sixty years earlier. Early in my research, it seemed to me that the late-twentieth-century representations and concepts of illicit drug addiction lacked the kind of insight and sympathy that Terry brings to the early-twentieth-century discourse of drug addiction. Terry's argument, I thought, is as relevant at the beginning of the twenty-first century as it was in 1921.

I still find Terry's description of "the psychology of the drug addict" as "the psychology of you and me when in pain" particularly poignant, and I still hope for this kind of empathy to inform contemporary discourses of drug addiction, as well as my own approach to the autobiographical narratives that I read in this dissertation. But what strikes me now about this passage is how astutely it anticipates both the absolute institutional authority under which "the drug addict" has come to exist, and the "network of intertwined discourses" (Derrida 229) of drug addiction that emerged in the twentieth century. Linking one's material, socioeconomic conditions to one's "mental state," for instance, Terry foreshadows psychosocial and sociological theories of drug addiction that make precisely this kind of connection.

His allusions to what we recognize today as traumatic experiences – degradation, persecution, intolerance as well as war and sexual assault – similarly anticipate psychiatry's recognition of psychological trauma as an overwhelmingly common etiological factor of drug addiction, especially for women. Indeed, it is noteworthy that Terry's only explicit reference to women involves interpersonal violence; as this project shows, women's narratives of drug addiction often begin with childhood incidents of sexual abuse and continue to catalogue traumatic experiences. Terry's words remind the reader that personal stories of illicit drug addiction are often stories of psychological trauma and suffering.

Yet, given medicine's creation of the field of drug addiction, and, indeed, the link between drug addiction as a field and medicine's ascendancy during the first decades of the twentieth century, Terry's voice as a physician seems oddly muted. Terry argues that "the psychology of the drug addict is the psychology of the average human being," yet he uses these emergent discourses to advance an also nascent disease model of drug addiction. He uses the notion that the drug addict is an essentially normal person who faces exceptional circumstances as proof of the functionalist disease model, which conceptualizes addiction as the physiological consequence of repeated drug use (Acker, "Stigma" 198).

My analysis of women's first-person accounts of themselves as illicit drug users and recovering addicts draws not only on the network of intertwined discourses of drug addiction that Terry evokes, but also on the history of these discourses.[1] In other words, I read women's narratives of drug addiction in this project through an interdisciplinary lens necessitated by the multiple and intertwined, and historically and culturally specific, institutional definitions of drug addiction.

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[1] From here on, when I use the terms "drug addict" or "drug addiction," I am referring to illegal drugs. I will specify prescription or licit drug addict when a distinction needs to be made.

I am concerned specifically with white, middle-class women's stories of drug addiction. This focus came about rather arbitrarily. Early in my research, while I was still surveying the vast and varied disciplinary terrain of addiction, I came across a copy of Stephen Kandall's *Substance and Shadow: Women and Addiction in the United States*. *Substance and Shadow* is a well-documented and concise history of women's drug use; Kandall, a professor of pediatrics, traces women's use of opiates, cocaine, marijuana, prescription drugs, and psychedelics in the United States from the mid-1800s up to the time of the book's first publication in 1996 (7). This history has been extremely useful most of all because Kandall incorporates women's direct voices where and when they illustrate a historical circumstance and/or support surveys and statistics, which has turned out to be invaluable. From *Substance and Shadow*, I compiled a list of published drug memoirs written by women; with the exception of *Oprah*'s addicted guests' stories, which are the focus of my last chapter, I first encountered the autobiographical narratives that I examine in this project in Kandall's history. As I made my way through the list, the absence of life-writing by Black, Hispanic, and Aboriginal women – those most stereotypically associated with and statistically affected by drug addiction – became very apparent. White, middle- and upper-class drug-addicted women, on the other hand, were obviously afforded a cultural voice.

While the prevalence of white, middle-class women's voices and the relative silence of "other" female addicts is certainly a reflection of socioeconomic privilege, I would also add that more than their racially "othered," lower-class counterparts, white, middle-class female drug addicts face a cultural imperative to tell their stories of drug addiction. Although these women have violated social and gender norms by becoming drug addicts, their original normativity assures that they can be recuperated and reintegrated into acceptable social roles. Put another way, white, middle-class drug-addicted women face an imperative to seek redemption, while their "othered" counterparts are more readily dismissed as "worthless junkies."

This imperative, furthermore, is historically persistent, even though the white, middle-class female addict is persistently forgotten. North American culture is remarkably amnesiac when it comes to illicit drug use among white, middle-class women; this broadly defined demographic emerges as the "new" and most alarming group of drug users with each "new drug" or renewed drug panic. Thus, the figure of the white, middle-class female drug addict (re)surfaces as the "new" addict several times throughout the twentieth century, most notably, at the beginning of the 1920s, during the 1960s, and again in the 1980s. And she is once again "new" and highly visible right now, at the beginning of the twenty-first century. As Nancy Campbell notes in her book, *Using Women: Gender, Drug Policy and Social Justice*, "When addicts are constituted as a social problem, 'women who use drugs' appear as a singular – and often spectacular – problematic. Historical amnesia makes its seem as if the repetition is a 'fad' and not a long-standing pattern" (9). My dissertation seeks to address this historical amnesia and the recurrent cultural erasure of white, middle-class women's drug use through reading the life stories that female addicts and recovering addicts produce at moments when *the figure of the white, middle-class female addict* becomes particularly visible. "The visibility of women's substance abuse," Campbell argues, "shifts relative to patterns of social change" (23). In each chapter, I map the specific historical and social circumstances of the women whose lives I read. I identify "patterns of social change" that render the white, middle-class female addict visible, and I examine how women make themselves culturally audible at these moments, how they meet the cultural imperative to tell their stories of addiction when they become spectacles as drug addicts.

As I explain in my first chapter, the first drug addicts to be named as such were white, upper- and middle-class women who had become addicted to opiates through standard medical practices of the late 1800s. This oft-overlooked bit of American history established a historically constant construction of white, middle-class addicted women as compulsory objects of medicine, as opposed to their lower-class, racially "other," often male counterparts, who are more often the objects of the law. White, middle-class women's conceptualizations of themselves as drug addicts, I show, rely on popular(ized) medical discourses of addiction. I argue that when these women become visible as drug addicts, they engage with popular medical(ized) discourses of addiction to construct life stories that earn them cultural audibility, authority, and redemption.

O.W., a young woman seduced by New York during the 1920s, for example, describes her drug addiction in her diaries as a psychological weakness, a condition inherent to her femininity; her interpretation of her addiction mirrors the attitude of every physician that she visits. Martha Morrison, a physician and psychiatrist, writes about her struggle during the early 1980s to accept her polydrug addiction as a "disease," a biochemical malfunction of the brain and liver, over which she has no control. Susan Gordon Lydon uses the 1980s and 90s feminist reconceptualization of psychological trauma to construct her drug addiction as a symptom of her traumatic past. *Oprah*'s guests' stories rely on the current prevalence of pathology as a kind of norm and reinscribe addicted women as blamelessly "sick." Psychological weakness, the disease concept, trauma, and normalized pathology each function as tropes through which white, middle-class addicted women not only make sense of their addictions and of themselves as drug addicts, but also garner an attentive and legitimating audience. Moreover, these tropes are specific not only to the historical and cultural moment of each woman's story, but also, I suggest, to the period's popular and medical discourses of drug addiction.

Dominant norms of femininity are also at stake in these women's stories of drug addiction and in their engagement with popular medical discourses of addiction. As sociologist Elizabeth Ettorre points out in her 1992 book, *Women and Substance Use*, and as my discussion of the historical amnesia surrounding women's drug use suggests, drug use has historically been thought of as a "man's disease" or a "male problem" (17). Arguing for a feminist perspective on women's drug use, Ettorre reveals the "masculinist" bias within the field of addiction: "the centrality of [the] notions . . . that men are socially dominant and active participants in the drug-using culture and women are socially subordinate and relatively passive participants has meant that the situations and needs of women were largely unacknowledged and unrecognized within both the treatment and research world" (17).

When women's drug use gets taken up by researchers, particularly psychiatrists and clinical psychologists working in the addiction field, the discourse most often reduces women's addiction to biological vulnerability (Campbell 13). As Campbell and other feminist critics have noted, "Gender-specific drug research investigates women's greater 'biological vulnerability' to addiction by studying interactions between sex hormones and neurotransmitters. . . . Gender difference is conflated with biological sexual difference" (19). "The differences that matter," asserts Campbell, "are men's and women's differential responsibilities for social reproduction" (13). Given women's responsibility for biological and social reproduction, the conflation of gender and biological difference in the discourse of women's addiction has resulted in the thorough stigmatization of women drug users. Ettorre explains,

> If women are seen to "abuse" in any way their already abused bodies, they are seen to be worse than their male counterparts. This is because these women are seen to defile and indeed to desecrate the sacred symbol of their sexual essence: their bodies which house their wombs or reproductive power. While the female body is the embodiment of women's reproductive nature, substance abuse is seen as an attack on women's nature. A substance-abusing woman is the quintessence of a wicked woman defiling her body with harmful substances. (10)

"The female 'junkie,'" Ettorre asserts, "is the embodiment of a woman who rejects her femininity" (12). Writing almost ten years later, Campbell attests to the persistence of this conceptualization of women drug users: "Women who use illicit drugs are widely figured as failures of . . . femininity, and maternity. They are represented as more socially isolated, degraded and stigmatized even by drug-addicted male subjects" (16). Put simply, drug use itself is seen as essentially un-feminine. Especially as it renders women morally reprehensible mothers and irresponsible wives, drug use violates normative femininity.

The narratives that I read in this project certainly substantiate the construction of drug use as a violation of femininity. In the personal stories with which I am concerned, drug use and addiction upset the feminine "domains of matrimony, motherhood, and appearance" (Friedling 17). In fact, recovery for white, middle-class women invariably consists of recovering this lost femininity and reestablishing heteronormative imperatives (Friedling 13). In *No Bed of Roses*, for instance, physicians repeatedly tell O.W. that "lady-like" behaviour will cure her of addiction. In Morrison's *White Rabbit*, "successful" recovery is signaled by heterosexual romance and marriage at the end of the book. Lydon's reunion with her daughter marks her "successful" recovery in the final chapter of *Take the Long Way Home*. Moreover, the medical(ized) concepts that women engage to explain their addictions often enable, or at least complement, the recuperation of "proper" female roles, such as wife and mother, and traits, such as emotiveness and nurturance.

In *Recovering Women: Feminisms and the Representations of Addiction*, Melissa Pearl Friedling complicates the construction of women's drug use and addiction as the inevitable violation of normative femininity. Referring specifically to representations of "young, white, bourgeois" addicted women, Friedling argues that "though these images are predominantly marked as *women*, they are ambivalent with respect to dominant norms of femininity" (12). She explains:

> The representations of these women often seem to flirt with the edges of "normal" sexual behaviour. Furthermore, the "unladylike" postures that the addicted woman strikes have been eroticized everywhere in culture, culminating in the phenomenon of "drug chic" or "fashionable addiction" . . .

> The submissive, vulnerable stance of the dazed addict offers her up as both sexually available and sexually dangerous: available in her compliant repose, dangerous in her unpredictable behaviour and nonstraight affiliations and, hence, often sharing discursive space with the ambivalent images of gays and lesbians. (13)[2]

Although Friedling is concerned more with visual images and representations of addicted women than I am, her articulation of the addicted woman's sexual ambivalence is useful for my purposes. Friedling implicitly draws on the historical association between white, bourgeois women's drug use and excessive female sexuality here. In the last decades of the nineteenth century, the scene of affluent, young white women lounging with Chinese men in opium dens came to dominate America's cultural drug consciousness. Women were both sexually vulnerable and sexually predatory in this popular scenario, which I discuss more thoroughly in Chapter One. As David Courtwright notes in his book, *Dark Paradise: Opiate Addiction in America Before 1940*, "It was commonly reported that . . . shameless [opium] smokers persuaded 'innocent girls to smoke in order to excite their passions and effect their ruin'" (78). Of course, "the fear of miscegenation made this spectacle all the more shocking" and all the more worthy of national concern (Courtwright, *Dark* 78). The dualism of white, middle-class women drug users' sexuality remains relevant today, although it is not as pronounced in the life stories that I read as it is in visual representations of drug-addicted women. Nonetheless, given the historical association between drug use and women's sexuality, which constructs excessive sexuality as a kind of feminine norm, women's illicit drug use is not always a definite violation of femininity.

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[2] White, middle-class addicted women share discursive space with an ambivalent image (Friedling 13) of a recovering gay man on *Oprah*'s 2003 show, "Did She Quit?" See footnote 11 in Chapter Four.

Another contradiction in the construct of women's drug use as a violation of femininity exists in the also historically persistent notion of women as vulnerable to illness. Women's inherent physical and psychological "weakness" made them, in the eyes of late-nineteenth-century medicine and society, particularly vulnerable to addiction. I discuss this notion thoroughly in Chapter One. The idea that women are inherently vulnerable to illness paints drug addiction not as a violation of femininity, but as a "natural" or at least unsurprising condition of it. While such notions circulate, as Campbell points out, in contemporary discourses of women's addiction as a consequence of their biology, they also consistently inform women's understandings of themselves as "sick" with addiction. That is, the women whose narratives I read in this project negotiate the paradoxical construction of drug addiction as both a consequence of women's vulnerability to illness and a violation of femininity. As I argue in my first chapter, and as evident again in my last chapter, this paradox has had long-lasting implications on the discourse of women's drug addiction.

"We're all addicts": The Contemporary Culture of Addiction

The rest of this Introduction is concerned with the contemporary ubiquity and power of the addiction concept in North American culture. I spent many hours early on in my research attempting to define addiction;[3] and while this pursuit is ultimately futile, which in and of itself is significant, it is important to begin with a map of the addiction field and a sense of the cultural currency of addiction, especially because, as I have suggested, the contemporary moment is one in which white, middle-class drug-addicted women are highly visible. Under the vast expansion of addiction attribution in the late twentieth and early twenty-first centuries, which typifies a broader cultural inclination to recast social problems as individual, internal, emotional, and medical problems, white, middle-class women are one of today's most dominant addict figures.

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[3] I'm not alone in my futile pursuit; researchers across the disciplines have devoted considerable energy to "defining" addiction. See for example, Ackers, "Addiction:

In her 1993 essay, "Epidemics of the Will," Eve Sedgwick identifies the final quarter of the twentieth century as the site of an "epidemic of addiction and addiction attribution" (135). "What is startling," she writes, "is the rapidity with which it has now become commonplace that, precisely, any substance, any behavior, even any affect may be pathologized as addictive" (132). Indeed, the last decades of the twentieth century witnessed a proliferation of so-called addicts. The exercise addict, the sex addict, the food addict, the relationship addict (also known as the codependent), the shopaholic, and the workaholic joined the drug addict and the alcoholic in a "narrative of inexorable decline and fatality" (Sedgwick 131). Suffering from the same "disease" as their substance-abusing counterparts, these new addicts likewise require medical intervention if they hope to disimplicate themselves from the inevitable "downward spiral" of addiction.

Peculiarly, the activities pathologized "under the searching rays of this new addiction attribution are the very ones that late capitalism presents as the ultimate

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The Troublesome Concept," Walters and Gilbert, "Defining Addiction: Contrasting Views of Clients and Experts," West, "Theories of Addiction," and Reissman and Carroll, "A New View of Addiction: Simple and Complex."

emblems of control, personal discretion, freedom itself" (Sedgwick 132-33). Citing the workaholic, the shopaholic, the codependent, and the sex addict, Sedgwick concludes, "As each assertion of *will* has made voluntarity itself appear problematical in a new area, the assertion of will itself has come to appear addictive" (133). She goes on to discuss the work of these addiction paradigms as the paradoxical propagation of the concept of free will: "so long as 'free will' has been hypostatized and charged with ethical value, for just so long has an equally hypostatized 'compulsion' had to be available as a counterstructure always internal to it, always requiring to be ejected from it" (133-34). Sedgwick argues that the same imperative is at work in the contemporary concept of addiction and its apparently limitless addiction attribution (134, 135). Put crudely, the late-twentieth-century incarnation of addiction is a response to a "historically specific point of stress" in the concept of free will (Sedgwick 135); and the instability of "free will" is a product of socioeconomic conditions and the social relations these conditions produce. "Why the twentieth century, and most of all its final quarter, should turn out to be the site of this epidemic of addiction and addiction attribution," writes Sedgwick, "must lie in the peculiarly resonant relations that seem to obtain between the problematics of addiction and those of the consumer phase of international capitalism" (135).

Without necessarily evoking the Nietzschian concept of free will, critics across the Social Sciences and Humanities offer similar explanations for the cultural ubiquity and power of the addiction concept at this historical moment. In his 1994 book, *False Fixes: The Cultural Politics of Drugs, Alcohol, and Addictive Relations*, David Forbes suggests that "*addiction* is no longer a medical term referring to biological processes but a common cultural signifier" (16). According to Forbes, the expanded concept of addiction refers to patterns of social relations, "everyday ways of relating" (Forbes 3) that reflect the patterns of North American culture as a whole (Forbes 16):

> In American culture people are not valued for their own sake but for their ability to accumulate power in a conspicuous manner within a competitive, controlling hierarchy. Addictions are intelligible in a culture in which many are estranged from mutual, equitable, self-enhancing relations in everyday life. That so many describe their lives as being out of control speaks to the nature of a culture in which control over others and being controlled by others are paramount. (15)

Forbes' account of the resonance of addiction in contemporary culture is a fairly standard sociological critique. Like many other cultural critics, Forbes emphasizes the role of consumer culture in perpetrating addiction and what he calls "addictive relations" (3). "Consumer culture itself has drug-like qualities" (13), Forbes claims. "The act of consumption, with its drug-like cycle of desire, tolerance, withdrawal, and renewed demand, now exists for its own sake, detached from production and material necessity" (13). He continues, "Addictive patterns . . . prevail as people attempt to seek pleasure, lessen pain, and gain a sense of power within a culture which uses commodities and commodified activities as drug-like things, which depends on the need to control other people and nature, and which denies a full range of experiences and voices" (15). Historian Caroline Acker also succinctly links the contemporary concept of addiction with consumerism: "The current pervasiveness of the addiction metaphor in the popular media suggests that a disorder involving unregulated consumption and out-of-control behavior resonates powerfully in a society that expects its members [not only] to be effective consumers," but also to construct their identities through consumerism ("Stigma" 203).

Other theorists point more directly to the psychological consequences of consumer-oriented capitalism (Potvin) to explain the prevalence of addiction. Psychologist Bruce Alexander, for example, has long argued that free market societies dislocate their members and that the psychological effects of such dislocation lead to "mass addiction" (Alexander, "Globalization" 501). In his article, "The Globalization of Addiction," Alexander contends that "intense interpersonal competition in the labour market, irresistible appeals to individualist expression in our consumption habits, and underfunded, neglected, and broken-down social institutions . . . have laid waste to the quality and quantity of our social connections" (qtd. in Potvin); under these conditions, addiction functions as a powerful substitute for gratifying social connections (Alexander, "Empirical").

The narratives of drug addiction that I read in this project attest to this theory of addiction, at least in part. Every woman describes not just periods of depression and loneliness, but a governing sense of isolation and non-belonging, which she directly relates to her addiction. Initially, being high brings a much cherished reprieve from these painful feelings. Encouraged by a new romantic partner or experienced in a new social setting, drug use also initially creates a sense of community for these women. While the women are often keenly aware of their emotional and psychological processes and states as they relate to their addictions, rarely do they make explicit links between their socioeconomic conditions, the roles these conditions dictate, and the painful feelings that influence their addictive behaviours.

Socio-psychological theories of addiction aim to make such connections clear. They generally identify and emphasize the dissolution of community under consumer-oriented capitalism as a governing factor of addiction. A dominant characteristic of contemporary North American culture, lack of community has damaging psychological consequences that render addiction an adaptive behaviour (Alexander, "Empirical").

During the 1920s and 1930s, three main disciplines – medicine, more specifically pharmacology, a then nascent psychiatry, and sociology – took up addiction as a distinct field of study (Acker, *Creating* 10). Today, addiction is the professed domain of many disciplines. Philosophy, cultural studies, literary studies, film studies, history, sociology, psychology, law, psychiatry, and medicine all take up issues of addiction and claim various degrees of authority over its conceptualization. Other fields or areas of study, within and beyond these disciplinary boundaries, also explore addiction. Addiction comes up in the study of trauma, for instance, which is itself a multidisciplinary area of research. An emergent interdisciplinary field, policy studies also addresses questions of addiction by examining the context and formulation of drug policy and legislation. Reflecting a paradigmatic shift in psychiatry from psychoanalysis to biological psychiatry, biopsychiatry and psychopharmacology have emerged as key fields in North American study of addiction. Furthermore, something called Addiction Studies exists, although there seems to be no consensus on what constitutes this field. Addiction Studies encompasses an enormous range of research projects and disciplinary approaches.

Everything from ethnographic studies of crack addiction among prostitutes to observations of neurochemical processes in people addicted to opiates, from analyses of the connection between creativity and drug use in Romantic poetry to professional training in how to counsel addicts, falls under the rubric of Addiction Studies (Vice 12). As Hale G. Lamont-Havers comments in a 1994 letter to *Dionysos: Journal of Literature and Addiction*, "the field of 'addiction studies' is now overextended. Anything goes" ("Symposium" 3).

While Lamont-Havers' assessment of Addiction Studies may be accurate, and I attest to being overwhelmed by the tremendous range of approaches to and material on addiction throughout my research, among the cacophony, certain disciplinary voices exist as authorities and construct a dominant discourse of addiction. Institutionally, multifactorial, "biopsychosocial" models have largely superseded single-factor explanations for addiction, as they have for almost all so-called psychological and/or behavioural disorders (Stoppard 84). Generally speaking, addiction experts across the disciplines, and within the various medical fields that study addiction, acknowledge the interaction of many etiological factors, including social and cultural alongside biochemical and physiological. Nonetheless, medicine, especially psychiatry, in its recent intersection with neurobiology, is the dominant expert or institutional voice on addiction. Certainly, it is medicine's disciplinary voice that most informs (or has been most translated into) the popular discourse of addiction; and it is this voice, I argue, that white, middle-class addicted women most engage and negotiate in their life stories.

Although theories, such as Forbes' and Alexander's, that explain the contemporary pervasiveness of addiction in relation to socioeconomic conditions are common within the academic realm of the Social Sciences, and although most institutional theories of addiction are multifactorial, little, if any, consideration is afforded to socioeconomic explanations when addiction is represented in popular culture. Even as addiction attribution has extended far beyond substance ingestion to include behaviour and affect, and although the locus of addictiveness can no longer be said to be the substance itself or even the body itself (Sedgwick 131; Forbes 3), the notion that addiction is a disease has gained popularity and authority as the addiction concept has expanded. The popular discourse of addiction reflects the cultural authority of medicine and the medicalization of behaviours. Representations and discussions of addiction within popular culture overwhelmingly refer to addiction as a disease.

As I discuss thoroughly in Chapter Two, Caroline Acker traces the shifting cultural utility of disease models of addiction from the late nineteenth century to the late twentieth century in her article, "Stigma or Legitimation? A Historical Examination of the Social Potentials of Addiction Disease Models." The most recent shift in disease models of addiction, which Acker characterizes as the "emergence of a nonpunitive disease model" ("Stigma" 202), occurred concurrently with the expansion of the addiction concept in the last decades of the twentieth century, "after 1970" (Acker, "Stigma" 202). "New patterns of drug use among new population groups" (Acker, "Stigma" 202), specifically (and most alarmingly) among white, middle-class youth, including women, during the 1960s and 1970s, prompted some to reconsider the dominant and stigmatizing psychiatric model of addiction, which "placed the etiology of problematic addiction in an individual's flaws of character structure" (Acker, "Stigma" 202) and therefore consigned addicts to a socially unacceptable role without hope of cure (Acker, "Stigma" 202). In addition to the changing demographics of drug use, Acker cites two other major conditions that effected the conceptual shift to a nonpunitive disease model:

> At the [U.S.] federal policy level, perceived public concern about drug-related crime and the high incidence of heroin addiction among returning Vietnam veterans prompted the Nixon administration to allocate substantial resources for treatment and to create the National Institute on Drug Abuse within the National Institutes of Health. In the private health care sector, especially in the 1980s, large numbers of drug users seeking care represented an important market opportunity. ("Stigma" 202)

In this setting, the disease model came to emphasize "behavior out of control (a system in disorder)" (Acker, "Stigma" 202) and to cite a combination of genetic inheritance and psychological and social environment as predisposing factors of addiction, rather than an inherent flaw in character structure (Acker, "Stigma" 202). The shift away from characterological to behavioural aspects also added a crucial element: recovery and thus social reintegration became possible (Acker, "Stigma" 203).

Today, despite the fact that addiction treatment remains focused almost exclusively on behavioural transformation as the means of recovery, the disease model emphasizes biological and neurobiological aspects of addiction and, subsequently, provides a conceptual framework for unifying biological and behavioural models of addictive behaviour (Acker, "Stigma" 203). Under the current conceptualization of addiction as a disease, the ideas that epitomize addiction (and emblematize contemporary Western culture) – loss of control and compulsiveness – are said to be rooted in neurobiological mechanisms and other often ambiguous biological processes such as genetic inheritance. This formulation legitimizes addiction as an involuntary illness and therefore offers the addict temporary exemption from "normal" social expectations as well as additional supports, such as insurance payments and paid leave from work (Acker, "Stigma" 195, 203) – at least for the middle- and upper-classes.

The disease model of the early twenty-first century reflects an increasing sense of powerlessness and vulnerability in contemporary Western culture (Furedi 7). The notion that addiction is a disease, as opposed to a deliberate and conscious behaviour, also corresponds with what Frank Furedi, among others, refers to as "the decline of an ethos of public responsibility" (Furedi 72; Shaffer 73; Szasz, *Ceremonial* 170-74). Critics of disease models of addiction have long argued that, with their focus on individual cases and biological causation, disease models "bolster denial that political factors like resource allocation or income distribution contribute to undesired or problematic conditions" (Acker, "Stigma" 197; Frans 77). However, the conceptual transformation of addiction epitomizes a recent broader cultural turn that has recast social problems as emotional ones and emotional problems as pathological ones. Under these cultural conditions, critics claim, responsibility to oneself overrides any sense of public and social responsibility (Furedi 73).

I share critics' concerns about the relationship between the pathologization of an increased number of behaviours as addictions and other "disorders" and a declining ethic of public responsibility. Certainly, the medicalization of habits such as shopping, gambling, and Internet use has "important consequences for the way society judges behaviour" (Furedi 122). As Furedi states,

> It is difficult to hold people to account if they suffer from one of a number of [medically diagnosed and therefore culturally validated] impulse-control disorders. . . . [R]ather than being condemned for their behaviour, such addicts are represented as victims of circumstances beyond their control and therefore worthy of our sympathy. (122)

This medicalization of behaviours also establishes "compulsive behaviours" and their resultant "disorders" as inherent, biological, or, more often today, neurobiological processes while socioeconomic and cultural factors and the social construction of these conditions are overlooked.

In his article, "Addiction as a Cultural Concept," Stanton Peele suggests that addiction is a new paradigm of subjectivity. He writes, "We are not so much misconceiving addiction as we are living in a culture increasingly controlled by a new notion of individual responsibility based on the addictive model." Following Peele, Furedi contexualizes the medicalization of behaviours and the contemporary pervasiveness of addiction in terms of a concurrent transformation of subjectivity. In his 2004 book, *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*, Furedi argues that

> society is in the process of drawing up a radically new definition of what constitutes the human condition. Many experiences that have hitherto been interpreted as a normal part of life have been redefined as damaging to people's emotions. . . . Invariably, the public is told that more and more people are afflicted with these emotional injuries. (5)

This turn towards what Furedi calls "emotionalism" – "the significance that contemporary culture attaches to making sense of the world through the prism of emotion" – is evident in the everyday use of therapeutic language and practices (1): "The vocabulary of therapeutics no longer refers to unusual problems or exotic states of mind. Terms like stress, anxiety, addiction, compulsion, trauma, negative emotions, healing, syndrome, . . . or counseling [and I would add, disorder and recovery] refer to the normal episodes of daily life" (1). The result, Furedi suggests, is "therapeutic culture" – a culture in which therapy is no longer only a clinical technique, a way of curing psychic disorder, but a way of thinking (22-23). "A culture becomes therapeutic," Furedi explains, "when this form of thinking expands from informing the relationship between the individual and therapist to shaping public perceptions about a variety of issues. At that point it ceases to be a clinical technique and becomes an instrument for the management of subjectivity" (22).

Therapeutic culture presents itself as "the harbinger of a new area of individual choice, autonomy, self-knowledge and self-awareness. . . . The language of therapeutics continually endorses the project of self-realization and holds out the promise of individual enlightenment through the exercise of autonomous behaviour" (Furedi 106). Yet, "the concept of the autonomous self is contradicted by powerful cultural messages about the inability of individuals to handle their emotions without support" (Furedi 107). Terms like "self-discovery" and "self-reconstruction," which are especially central to the project of recovery from addiction as it is conventionally narrativized, describe processes that are not actually undertaken by the self (Furedi 107). As Furedi notes, "These are projects which are guided by a detailed cultural narrative and often with the guidance of professionals" (107).

In the case of addiction and recovery, these processes of self-reconstruction are certainly "guided by a detailed cultural narrative" and are almost always "guided by professionals." In fact, a crucial element of the cultural narrative of addiction and recovery is the imperative of professional, usually medical, intervention. Addiction "experts" and laypersons alike routinely profess that recovery from addiction is not possible without professional "help." Sedgwick anticipates this situation when she describes the narrative of addiction that emerged in the late nineteenth century as the taxonomic reframing of a drug user as an addict occurred:

> From being the subject of her own perceptual manipulations or indeed experimentations, she is installed as the proper *object* of compulsory institutional disciplines, legal and medical, that without actually being able to do anything to 'help' her, nonetheless, presume to know her better than she can know herself – and indeed, offer everyone in her culture who is not herself the opportunity of enjoying the same flattering presumption. (131)

Today, the Twelve-Step recovery model, based on Alcoholics Anonymous, is popularly upheld as the only way to recover from addictions. Moreover, within the dominant Twelve-Step model, recovery requires one to rewrite the narrative of the self. Of course, the Twelve Steps offer the appropriate script, and it is one of a powerless and vulnerable self. The first step of the Twelve Steps is to admit that one is powerless over a specific substance or behaviour and that life is unmanageable as a consequence (www.AA.org). This powerlessness is not a temporary condition, dependent solely on the addict's compulsive behaviour; rather, the dominant rhetoric of recovery holds that the addict is constantly vulnerable to addiction and must be on guard against her compulsive, addictive behaviour for the rest of her life.

In their insightful article, "Twelve-Step Teleology: Narratives of Recovery/Recovery as Narrative," Robyn Warhol and Helena Michie explain that "the acquisition and continual retelling of the [Twelve-Step] story becomes the very process that constitutes the [addict's] self" (340). They observe the paradoxical character of this process of identity acquisition within the Twelve-Step framework: "the recovering [addict] adopts a new identity, but the identity is a deindividualized or 'anonymous' one: the 'self' that exists in the world of social interaction within [Twelve-Step programs] has no distinguishing appellation. . ." (340). What does distinguish this name and identity from other names and identities, however, is its stasis and the permanence of pathology as the basis of selfhood – the addict is always an addict. In other words, for the so-called recovering addict, addiction remains the defining feature of her identity.

These narratives of addiction and recovery epitomize a general cultural dependence on therapeutics for the realization of the self. But, as Furedi suggests and as the Twelve Step's "deindividualized" identity exemplifies, the dependence on therapeutics for the realization of the self calls into question the meaning of individual autonomy (Furedi 107). Therapeutic culture, Furedi asserts, "continually diminishes the sense of individual self and promotes a distinctly feeble version of human subjectivity" (107). It has helped construct "a diminished sense of self that characteristically suffers from an emotional deficit and possesses a permanent consciousness of vulnerability" (Furedi 21). "The self," in Furedi's words, "is presented as constantly subject to grave injury and illness" (107). The insistence that such risks are part of everyday life, according to Furedi, "heighten[s] the individual's sense of vulnerability and disposition to illness" (107) and establishes the exact parameters by which the individual is drawn back into medical discourse. The self under the current therapeutic regime, therefore, is what Furedi labels "the diminished self" – a subjectivity guided by the cultural "aggrandizement of victimhood, a lowering of expectations about human competence and agency and an increasing reliance on therapeutic intervention" (Wainwright and Calnan qtd. in Furedi 113).[4]

Contemporary dominant cultural narratives of addiction, particularly women's addiction, and representations of female addict figures exemplify this kind of subjectivity and reflect the prominence of the emergent "therapeutic ethos" (Furedi 23).[5] The keenness with which we pathologize emotions and behaviours as addictions, and the readiness with which we accept and refer to addiction as a "disease" that is beyond our control, both reflects and promotes a reduced sense of personal or individual agency as well as a greater sense of medical and therapeutic authority.

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[4] Although he never mentions Foucault, Furedi's account of therapeutic culture and the "diminished self" are Foucauldian, as is my understanding of the kinds of subjectivities produced in this contemporary therapeutic regime. In Foucauldian terms, therapeutic culture is a "mode of subjectification," an ethical code that structures individual's lives and constitutes their identity (Foucault qtd. in Gutting 101-2). The subject produced under the therapeutic regime, and its purported goal of self-mastery, is one that inevitably recognizes, or more accurately, produces its own deficiencies; it surveils and disciplines itself. Foucault introduces the notion of the subject as self-disciplinary in *Discipline and Punish* (see especially pgs. 135-41 and 195-228).

[5] Furedi uses the terms "therapeutic culture," "therapeutic ethos" and "therapeutics" interchangeably (23).

These cultural conditions and "diminished" subjectivity are particularly evident in the contemporary narratives I read in this project where the self-reflexive imperative of autobiography merges, first, with the challenge to selfhood that addiction poses (according to its dominant cultural narratives), and, second, with recovery's central project of self-reconstruction, as well as more broadly with gendered constructs of selfhood. In his book, *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*, Anthony Giddens describes "the addictive experience" as "a giving up of self, a temporary abandonment of that reflexive concern with the protection of self-identity generic to most circumstances of day-to-day life" (72). "The loss of self," therefore, is characteristic of addiction (Giddens 73). Indeed, in their autobiographical stories, women invariably lament the loss of self (and they actually use this phrase) as the overarching consequence of their addictions and describe recovery as a recuperation or a discovery of self.[6]

The loss of self occurs not just as an inherent characteristic of addiction, however. In their narratives of addiction, women invariably recount experiences of victimization and trauma, which also upset their concepts of self and require therapeutic intervention. Furthermore, these experiences – victimization, trauma, the loss of self, and therapeutic treatment – are distinctly gendered; they are more commonly seen as women's experiences than men's.

Women's personal stories of addiction also illustrate Furedi's notion that one of the main ways that contemporary culture now makes sense of the world is through emotions. Recounting emotions deliberately and unconsciously concealed by addiction as well as emotions awakened and embraced in recovery, the women often implicitly accept the cultural presumption that the state of our emotions is the cause of problems faced by contemporary society (Furedi 25), a presumption Furedi calls "emotional determinism" (25). Indeed, dominant discourses of addiction and recovery emphasize the centrality of "unprocessed and unmanaged emotions" (Furedi 27) as etiological factors of addiction and subsequently promote the idea of "emotional intelligence" (Furedi 27) as a means of recovery. "Emotional intelligence," according primarily to the self-help movement, can be achieved through the act of writing. Some psychologists and psychotherapists also encourage storytelling as a means of healing and propose narrative as a treatment approach to addictions.[7] Whether conceived in professional terms as "narrative therapy" or by the women themselves as simply recording and recalling their feelings and experiences, narrativizing experiences of addiction allows the addict to "work through" suppressed emotions that underlie her addiction and "deal with" newly realized emotions that recovery brings.

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[6] While the women eventually mourn the loss of self as a consequence of their addictions, they also overwhelmingly cite the obliteration of self as a goal of their drug use.

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[7] See Jonathan Diamond's *Narrative Ends to Sober Means*. Diamond argues that the act of narrativizing one's experiences of addiction allows one to make meaning of the addiction and to understand one's ties to the substance or behaviour, which puts into motion the process of recovery. He bases his model on psychotherapists Michael White and David Epston's 1990 book, *Narrative Means to Therapeutic Ends*.

As an aside, narrative therapy is not a new therapeutic concept and, in fact, feminist therapists have been writing about the importance of narrative in therapeutic settings since the early 1980s (Gremillion 193). Narrative therapy "grew out of a critique of psychiatric 'objectivity' and is inspired by the idea that therapeutic practices are never culturally neutral, because they help reconfigure persons' lives and relationships in particular social contexts" (Gremillion 193). For an insightful discussion of the development and theoretical premise and practice of narrative theory, see Helen Germillion's "Epilogue: A Narrative Approach to Anorexia" in *Feeding Anorexia: Gender and Power at a Treatment Center* (Duke UP, 2003). Also see Johnella Bird's *The Heart's Narrative: Therapy and Navigating Life's Contradictions* ,(Edge, 2000) and John Neal's "Narrative Therapy Training and Supervision" (1996).

Most of us are probably familiar with the pop-psychology explanation of addiction as the "avoidance of emotional pain" (Vincent qtd. in Furedi 122). To various ends, this idea has circulated since the invention of the addict at the end of the nineteenth century. When America's first "drug panic" occurred during the first decades of the twentieth century, when drug addiction was first made visible as a social problem, the notion that drug addiction was a response to intense psychological pain radically defied dominant attitudes towards drug use, which deemed the drug addict inherently degenerate and criminal. Today's conceptualization of addiction as the avoidance of emotional pain, some critics would suggest, performs similar cultural work by encouraging us to recognize the addict as a suffering person rather than an inherently bad one, thereby reducing the stigma of addiction. As a reflection of "emotional determinism" (Furedi 25), however, the contemporary conceptualization of addiction as the avoidance of emotional pain more often works to shift our cultural focus from the social to the internal without considering how the two are intricately linked.

I do not mean to suggest that psychic pain is socially and politically irrelevant. Many women tell their stories expressly to politicize their emotional and psychic pain, echoing the second-wave feminist mantra, the personal is political. Writing from and drawing on the consciousness raising efforts of women during the 1960s and '70s, Susan Gordon Lydon, for instance, draws important connections between her addiction, feelings of shame and helplessness, experiences of abuse, and systemic sexism in her memoir, *Take the Long Way Home*. While the expansion and reconceptualization of addiction in the late twentieth and early twenty-first century as an emotional, psychological and medical problem typifies the current cultural inclination to recast social problems as individual, internal, emotional problems, the understanding of addiction as an avoidance of emotional pain *can* also encourage us to recognize the connections between emotional pain and social conditions. I explore this potential in Chapter 3 via an analysis of Lydon's use of trauma as a narrative framework for her story of addiction. The process of becoming "emotionally literate" – of recognizing and naming feelings and their (often childhood) origins and implications, and learning how to "deal with" them – is more often a central convention of contemporary women's addiction narratives than it is a political strategy, however. Visits to various therapists, Twelve-Step group meetings, and other epiphanic therapeutic encounters that occur, for example, while watching *Oprah* or reading other personal stories of addiction, organize the life story and addiction narrative.

Almost fifteen years after Sedgwick described the final quarter of the twentieth century as the site of "epidemic of addiction and addiction attribution" (135), cultural critics continue to cite the expansion of addiction attribution as the defining feature of the current conceptualization of addiction. Many critics, myself included, are still concerned with the implications of pathologizing heretofore "normal" behaviours and affects as addictive, and rightly so. Vast numbers of people, many of whom epitomized "normality" as white and middle-class, have been brought under the hierarchal control of the medical establishment and an attendant therapeutic regime with the expansion of addiction attribution. The continued expansion of addiction in the early twenty-first century has created a troubling paradox: addiction, and pathology in general, have been normalized. As a recent local daily magazine headline proclaims, "We're all addicts: From food to porn to video games, our vices are what unite us" (*Dose* 13 March 2006).[8] According to the popular discourse of addiction, not only are we all (regardless of class, ethnicity, or gender) susceptible to addiction, it is "normal" to have addiction *befall* us. To be sick with addiction, but nonetheless "normal" in such illness, reflects a pervasive consciousness of vulnerability and powerlessness (Furedi 120) and raises a host of questions about subjectivity, responsibility, pathology, and the relationships between emotional pain and social institutions and conditions.

Lost in the crowd? Locating the Illicit Drug Addict

If addiction is now a "normal" pathology, and "addict" is a socially acceptable identity, how has the figure of the "junkie," the illicit drug addict, changed? Where does the expanded concept of addiction leave this original addict figure?

While the terms of addiction are no longer conceptualized primarily around or embodied by the drug addict, drug addiction nonetheless continues to function as a paradigm for representing new categories of addiction. In other words, although the definition of addiction has expanded to regard every form of behaviour as potentially addictive, an extensive repertoire of sensationalist images and the dogmatic rhetoric of illicit drug addiction continues to shape the representation of any and all addiction, albeit to varying degrees and depending on who is addicted. After all, since the Nixon administration coined the term in 1971 (Musto 248; Jonnes 261), the "War on Drugs" has shaped some of our most influential cultural narratives of addiction. The powerfully stigmatizing rhetoric of the "War on Drugs" has left us, for example, with a narrative in which the drug has complete agency: the drug beckons, seduces, and hooks the user. As the contemporary cultural sense of powerlessness demonstrates, we continue to afford such agency to the myriad of behaviours we now deem addictive. The perpetuity of addiction trends – the "next new drug" or the "next new addiction" – is also a legacy of the "War on Drugs," which reproduced a single narrative with each new apparent trend in drug use.[9] As Nancy Campbell notes in her book, *Using Women: Gender, Drug Policy, and Social Justice*, "there is always a 'next drug,' a set of emergent harms, a more alarming group of users, a cyclic sense of urgency, and new numeric confabulations to document the escalation of drug use beyond the controls designed to contain it" (38). Although the new addictions do not explicitly come under or exceed institutional controls in the same way as illicit drugs do (food consumption, for example, is not regulated by federal legislation and compulsive Internet use is not legislated as a criminal act), they nonetheless take up a similarly recurrent alarmist and urgent narrative that depends on a sense of exceeding and/or transgressing certain cultural controls and/or norms.

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[8] This notion that our addictions "unite us" is somewhat ironic given that "unity" was precisely the fear that motivated anti-drug campaigners during the late nineteenth and early twentieth century. As Marek Kohn writes, "the worst thing about drugs was that they dissolved boundaries between the races, and positively encouraged sexual contact across the colour lines" (2). From the late 1870s to the 1920s, anxiety about drug use focused on the Chinese opium dens of America's new urban centers where different classes, ethnicities, and genders most noticeably came together. Kohn succinctly summarizes the anti-drug rhetoric of the time: "If the ultimate menace of drugs had to be summarized in a single proposition, it would be that they facilitated the seduction of young white women by men of other races" (2).

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[9] I use the past tense tentatively here. The "War on Terror" seems to have replaced the "War on Drugs," at least for now. For a brief but insightful discussion of how the two so-called wars discursively intersect, see Mary Pat Brady's "Quotidian Warfare" in the Autumn 2002 issue of *Signs*. Brady contends that the "War on Drugs" "functions as the critical but disavowed model of this latest offensive" (446), the "War on Terror."

Furthermore, the new addicts – the sex addict, the exercise addict, the food addict, the compulsive shopper, the codependent, the Internet addict, etc. – find themselves in the same "narrative of inexorable decline and fatality" (Sedgwick 131) as their drug-addicted counterparts. They too narrate their experience of addiction as a "downward spiral" that hurtles them to some version of "rock bottom" before they seek redemption in recovery. The new addicts often borrow the idiom of illicit drug use and addiction, referring to themselves, for example, as "junkies" in need of a "fix." With surprising frequency, addicted women in particular apply a demonizing rhetoric of illicit drug addiction to themselves, evoking early-twentieth-century notions of drug addiction to explain their addictions as the shameful product of inherent characterological flaws and moral weakness. Moreover, they often draw on the rhetoric of drug addiction to authenticate and validate their experiences of addiction. In other words, perhaps because addictions and compulsive behaviours are now so common, the new addicts adopt the discourse of drug addiction to lend a sense of seriousness or gravity to their experiences.

Notably, however, only people who can easily extricate themselves from the most disturbing connotations of drug addiction – homelessness, degradation, worthlessness, for example – can adopt the discourse of drug addiction to convey the urgency and severity of their problems. In other words, the new addicts who take up the language of drug addiction to describe their addictions usually occupy privileged positions as white and middle- or upper-class. Their white, middle-class privilege allows them to retain their individuality at the same time as they take on the otherness associated with drug addiction (Friedling 13). The assumption of recovery is also part of this privilege. White, middle-class addicts, regardless of what they are addicted to, are recuperative; they are afforded specific institutional channels for recovery and can recover because they still embody normativity in ethnicity and class.

These are the same addicts to whom the disease concept is readily applied today. As a culture, we more willingly accept the new addict figures as innocent victims of the "disease" of addiction than the drug addict. While psychiatrists and other medical professionals routinely appear as "experts" on television talk shows, for example, to testify that "all addictions are the same," and all addictions are a function of the same "progressive and chronic illness," representations of drug addiction are usually more inflected with moral overtones than representations of other addictions.

This bias is evident also within the medical profession. As Brian Vastag notes in a 2003 article in the *Journal of the American Medical Association*, "the idea that [drug] addiction is simply a consequence of willfulness still permeates the [medical] profession" (1299). Citing several speakers at the College for the Problems of Drug Dependency annual meeting, Vastag concludes, "For all the lip service paid to the concept of addiction as a medical disease, the idea has yet to gain traction with a large proportion of physicians. They, like many others in society, often regard abuse of alcohol or drugs as a moral or behavioral problem" (1299).[10]

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[10] In this article, Vastag quotes "noted addiction specialist" Charles O'Brien, who argues that "addiction is a brain disease" (1299). O'Brien continues, "But when you

In her most recent work, *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control*, Caroline Acker identifies a systemic prejudice in the treatment of drug addicts. She writes:

> We now have in the United States a two-tier system of response to drug dependence: treatment for the middle and upper classes and incarceration of most others, including the poor, the uninsured, ethnic minorities, and immigrants. Employment status, race, gender, and class all influence which response an individual encounters. (9)

This distinction is crucial for my work. The women whose narratives I study all begin and (for the most part) end their stories from privileged positions of upper or middle class and normative femininity. It is important to recognize that they are subject to a different institutional response and disciplinary regime than those most stereotypically associated with drug addiction. As my argument that white, middle-class addicted women engage with popular medicalized concepts of addiction to earn a cultural presence suggests, the discrimination that Acker so succinctly delineates here has a discursive counterpart. While I would not go as far as to say that we have two distinct, exclusive discourses of drug addiction – one for the upper and middle classes and one for everyone else – a discursive parallel to the

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say that . . . , people get very angry. It's something we have to continue selling" (qtd. in Vastag 1299). In keeping with the current cultural fascination with and medical privileging of the brain, neurobiological theories of addiction are increasingly popular. What is particularly striking here, however, is O'Brien's use of the word *selling*, which links the medical discipline to capitalist enterprise and consumerism. While O'Brien might argue that he simply meant medicine has to continue *promoting* the idea that addiction is a brain disease, "selling" reminds us that medicine is a powerful economic institution and industry and that its discourses are inextricably tied to its economic role. O'Brien's comment leaves me wondering, what are we buying if we accept the idea that addiction is a brain disease?

"two-tier response to drug dependence" (Acker, *Creating* 9) certainly is discernable: drug addiction among the upper and middle classes is generally medicalized while most others remain the objects of a punitive, stigmatizing discourse.

This discursive distinction is not always clear or stable, however. In their narratives, women often internalize society's punitive attitudes towards illicit drug addicts of lower classes and ethnic minorities; they come to see themselves as "worthless junkies." Some women embrace the deviant addict identity, finding it liberating from the expectations of their class and gender. For periods during their addictions, women lose the privileges of normativity as they work as prostitutes, squat in derelict buildings, lose custody of their children, or get arrested for trafficking, for instance. At times, these women occupy the terrain of the "other" and are subject to punitive disciplinary and discursive practices.

Ultimately, however, their histories of upper or middle-class status and normative femininity permit them the possibility of recovery. Rather than being automatically and unconditionally incarcerated, white, middle-class addicted women are offered "hope" through medicine and popular medicalized models of addiction. Nonetheless, their stories intertwine the punitive discourse of drug addiction, to which lower class addicts and addicted people of colour are subject, with the popularized medical discourse of addiction. Thus, the stereotypical drug addict still plays an important role even in representations of drug addiction among white, middle-class women.

Stereotypically, the morality of the drug addict is inevitably suspect. In Acker's words, "Whatever the drug or the label attached to the user, the stereotype is of an individual taken over by drugs who becomes oblivious to expected social roles and the normal demands of life" (*Creating* 6), and herein lies the tacit moral transgression. The drug addict is "a potent negative symbol of inverted social roles" (Acker, *Creating* 7), regardless of his or her historically and culturally specific moniker. After all, addicts are thought to abandon all responsibilities and sever social and affectional ties (Acker, *Creating* 7), which makes them not just suspect but outright dangerous to society, according to the dominant discourse of drug addiction.

The drug addict has largely retained a stigma of deviance and hopelessness, particularly in popular culture. Ever the toughened criminal, the junkie hustles his way through the gritty streets and grand courts of primetime crime TV. The female drug addict also makes regular appearances on these popular television dramas; if she isn't the corpse that makes for a captivatingly gruesome opening frame, she is a "passive, exploited, degraded victim," most likely a prostitute, "ready to sell her body for the price of her next dose" (Palmer and Horowitz 11). Similar villains and victims inhabit film and fiction. From time to time, the drug addict, or rather her heavily stylized likeness, slinks down the catwalk and, with glazed eyes, peers out from the glossy pages of fashion and lifestyle magazines. A "passive, exploited, degraded victim" she may be, but, taken up by consumerism, she is also a marketable commodity. The drug addict appears, too, in the popular media that professes reality; current affairs programming, talk shows, and the nightly news relay status reports on the latest "evil drug" and/or offer the addict a chance at redemption in return for her nationally-broadcast confession. Newspaper headlines proclaim one drug after another uniquely addictive and likely to produce bizarre, usually violent, behaviour (Acker, *Creating* 6).

With every sensationalized trend in drug use, an apparently new figure of drug addiction joins an already long cast of stereotypical addicts. During the late 1980s and early 1990s, for example, the "crack mother" and the "crack whore" emerged from the so-called "crack epidemic" among America's poor, inner-city, not to mention Black, residents to become "objects of public hostility" (Humphries 5). When crack use failed to live up to its prophesized epidemic status and diminished by the mid-to-late 1990s, stories of crystal meth (methamphetamine) picked up the theme of rapid addictiveness (Acker, *Creating* 6). Since the late 1990s, crystal methamphetamine's media profile has grown significantly; it is safe to say that crystal methamphetamine is, in Campbell's terms, the current "next drug," replete with the familiar rhetoric of epidemic use and alarming "new" groups of users, including young, white, middle-class women. I examine representations of these latest "new" users and addicts, who are arguably methamphetamine's most highly publicized "victims," in Chapter 4. They are particularly important because they embody the paradox of the addict figure in addiction's contemporary conceptualization: they appear "normal," but they are pathological; they are pathological, but that is "normal."

Likewise, increasingly, drug addiction is only remarkable when it affects "normal" (read: white, middle-class) people; it is especially noteworthy and visible when young, white, middle-class *women* are affected. Unlike addicted women who live in or have "disappeared" from Vancouver's infamous downtown lower eastside or Edmonton's downtown, the majority of whom are Aboriginal women, these young, white, middle-class women are afforded a voice, but not unconditionally. They face a cultural imperative to tell their stories, to share the most private details of their lives in the most public of forums, in exchange for therapeutic "help" and cultural redemption. We need to ask, what must they say to be heard?

While stereotypes of drug addicts as "down and out," hopeless, homeless, criminal, gangsters, and prostitutes persist and inform representations of other types of addicts, these figures are increasingly less visible under the vastly broadened concept of addiction. Because we hear and read so much about the commonality of addictions and about addiction as a "disease," a biological, medical condition, increasingly less popular attention is paid to drug addiction as a socioeconomic and political issue. While the "inherently bad" or "deviant" drug addict still appears in television crime scenes and on cinematic urban streets, the disenfranchised drug addict is less spectacular and politically relevant than s/he was throughout the twentieth century. It is those that appear "normal," perform their "proper" roles, and occupy privileged socioeconomic and ethnic positions *and* identify as addicts that now captivate us.

In this cultural constellation, and under the expanded concept of addiction, the white, middle-class woman is a dominant addict figure. As Friedling notes, "a quick review of contemporary popular cultural representations . . . reveal[s] that the preponderance of images of addiction are also images of [white] women" (12-13). Although we might expect her to be disproportionately affected by the new addictions, especially by gendered behaviours such as shopping, loving, and eating, the white, middle-class woman is arguably most visible and most significant as a drug addict. Put another way, drug addiction is frequently embodied by white, middle-class women.

The "newness" of drug use and addiction among white, middle-class women, although erroneously cited, is a major factor in the contemporary prominence of the white middle-class female drug addict. As I suggested earlier, the white middle-class female drug addict currently garners so much popular attention because she is seen to be part of a population heretofore unaffected by or somehow immune to drug addiction. At the same time, however, under the current pervasiveness of addiction, she is expected to be affected by some variation of this "illness" and to recount her experiences of it publicly. Moreover, she has a significant cultural presence at the moment as a marketable commodity. The white, middle-class female drug addict appears regularly on America's most popular television talk show, *Oprah*, in the pages of women's fashion magazines such as *Glamour*, and on bookstore shelves in memoirs that populate the ever-growing Self-Help, Recovery, and Psychology sections. We might say that she sells the idea of addiction. Of course, she is also the intended consumer. I unpack the dynamics of this relation in my final chapter as I return to the contemporary visibility and currency of the young, white, middle-class drug-addicted woman.

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This dissertation is organized chronologically; I start with O.W.'s account of life as a young addicted woman in the 1920s and wind my way through the twentieth century to the present moment where *Oprah*'s addicted guests produce internationally televised oral autobiographies. As I have already shown, addiction has a relatively short history, and the women whose stories I read here negotiate this history as they construct themselves as illicit drug addicts and make sense of their addictions through a network of intertwined discourses.

Analyzing *No Bed of Roses: The Diary of a Lost Soul*, Chapter One focuses on the treatment available to O.W. as a young, middle-class woman and a drug-addicted prostitute in America's new urban centers during the early 1920s. Examining O.W.'s experiences in medical institutions and treatment facilities provides insight into the then-nascent medical discourse of addiction and introduces competing and often contradictory theories of drug addiction that resonate throughout this project. I argue that the treatment O.W. receives reveals a cultural ambivalence around the female drug addict that reflects not only the transformation of the addict at the turn of the century, but also women's changing roles. Wrapped up in femininity, ethnicity, and class, this initial ambivalence is historically persistent, and, in fact, paradigmatic of the female drug addict, as the rest of my dissertation shows.

A significant portion of this chapter is devoted to describing *No Bed of Roses* and its generic ambiguity. Specifically, I raise questions about the book's authenticity as a woman's first-person account of her life as a drug addict. Despite the book jacket's repeated claims of authenticity, and despite the few historians who describe *No Bed of Roses* as the first published voice of drug-addicted women in America (White, "Women"; Palmer and Horowitz 128; Kandall 105), the plot and O.W.'s often self-deprecating interpretations of herself as a "dope fiend" sometimes tend towards the propagandistic. The book partially reproduces the white slave narrative, for example, a popular cultural narrative that circulated especially during the 1910s and 20s amidst fears of miscegenation (Campbell 81). I recount my quest to answer the question of the book's authenticity through email conversations with Michael Horowitz, one of the editors of *Shaman Woman,* *Mainline Lady: Women's Writings on the Drug Experience* (the only collection of women's writings on the drug experience that I've found), and Ed Reith, an American bookseller who described *No Bed of Roses* as "fiction" in his online posting at abebooks.com. I do not pose a definitive answer to the question of the book's authenticity; instead, I suggest that *No Bed of Roses* is highly-mediated first-person account of one woman's (O.W.'s) experiences of drug addiction in early-twentieth-century urban America. Whether *No Bed of Roses* is, as the jacket reads, "the actual diaries of a prostitute and a dope fiend," it nonetheless offers insights into the emergent medical discourse of women's drug addiction and cultural attitudes towards the female drug addict. O.W.'s account exemplifies a cultural ambivalence towards addicted women and illustrates the contradictions encoded in the figure of the female addict. Both this cultural ambivalence and the contradictory characteristics of the figure of the female addict, which, as I discuss, reside in turn-of-the-century cultural transformation and relates to "the taxonomic pressure of the newly ramified and pervasive medical-juridical authority" (Sedgwick 130), resonate throughout twentieth-century women's conceptualizations of themselves as addicts.

In Chapter Two, I suggest that the late-twentieth-century disease concept of addiction reveals a persistent cultural ambivalence towards white, middle-class addicted women and perpetuates contradictory traits in the figure of the female addict. Although white, middle-class women more readily fall under the sheltering effects of the supposedly nonpunitive disease concept, female addicts are still regarded as either blameless "victims" of the "disease," or are held individually and completely responsible for the "disease." This chapter begins with a historical overview of the disease models of addiction; again, this historical context shows how discourses get woven together to affect the concept of addiction and shape the way addicted women make sense of themselves as addicts.

In this chapter, I examine Martha Morrison's use of the disease concept as a narrative framework for her autobiography, *White Rabbit: A Doctor's Own Story of Addiction, Recovery and Survival*, and discuss the social utility of the disease concept in the construction of her addict identity. Morrison, I argue, is part of the population most served by a shift in the disease concept during the 1970s and 80s. Having acquired her drug habit during the 1960s, Morrison, a young, white, middle-class, professional woman, exemplifies the "new" demographic of America's drug users. Illicit drug use among "Middle America" could not be explained by poverty or race, and could not be accepted as a mark of criminality or psychological deviance as it had been throughout the middle decades of the century. A conceptual shift in the disease model away from the psychiatric towards the physiological and biological fit the bill, and the concept of addiction as a genetically inherited "disease," located primarily in the brain, emerged after 1970. As the disease model becomes non-punitive to accommodate a new demographic of drug addicts, Morrison enters a residential treatment program for addicted physicians. As a physician and a psychiatrist, she is also part of the institution that, particularly during the 1970s and 80s, when she was in medical school, promulgated the concept of addiction-as-disease. I explore how Morrison's multiply privileged subject positions are maintained by her use of the disease concept. Analyzing Morrison's representation of class and gender in relation to her addict identity, as well as her identity as a medical authority, I argue that Morrison's story exemplifies the tendency of the late-twentieth-century disease concept to maintain middle-class privilege and heteronormativity.

Morrison's negotiation of the disease concept crystallizes many of the themes that circulate in dominant discourses of addiction: the concept of responsibility, the heteronormative imperative of recovery, the medicalization of behaviour, and the perceived relationship between femininity and illness. These themes recur in the trauma narrative that Susan Gordon Lydon uses to frame her story of drug addiction in *Take the Long Way Home: Memoirs of a Survivor.* The relationship between psychological trauma and women's drug use has been one of my main interests since this project's conception. Chapter Three explores the effectiveness of trauma as a feminist framework for representing and understanding women's drug addiction.

A self-identified pioneer of second-wave feminism, Lydon adheres to the second-wave mantra, *the personal is political.* Her memoir represents and illustrates one of the most significant legacies of second-wave feminism: the feminist foray into trauma theory, which effected the reconceptualization of trauma to include women's everyday experiences of interpersonal violence, the development of the concept of "insidious" trauma, and the depathologization of adaptive response to trauma. I open this chapter by locating the feminist contributions to trauma theory within the historical context of the 1970s and discuss how the feminist movement brought the psychological trauma of sexual and domestic violence into public consciousness during this period. Turning to Lydon's memoir, I consider how she engages with each of these three feminist interventions as she constructs a trauma narrative as the interpretative framework for her addiction.

In the first section of *Take the Long Way Home*, Lydon outlines what she sees as the main psychological factors of her addiction: her problematic Jewish identity, experiences of incest at the hands of her maternal grandfather, a physically and emotionally abusive relationship with her father, and a discomfort with the femininity that she learns from her mother. She conceptualizes each of these factors as trauma and links them to her addiction. Her descriptions of these events, particularly the incest and physical and emotional abuse, reproduce empirical and clinical psychiatric and psychological discourses of trauma. I argue that these clinical overtones lend authority to her voice and anticipate a similarly clinical theory and medical narrative that links trauma and drug addiction.

Throughout the chapter, I draw on psychiatric concepts of trauma and addiction, and explore psychiatry's etiologies of drug addiction, which, as I suggested earlier, cite trauma as a key factor. While I still find trauma a useful and potentially political (or at least potentially politicizing) lens through which to view women's drug addiction, I end the chapter with a brief discussion of how and where the trauma narrative fails women. When Lydon is in recovery, at a residential treatment facility called Women, Inc., the social and political dimensions of her addiction, which she highlights through her use of trauma, disappear entirely from her narrative. The discourse of recovery erases the culture of oppression that Lydon so carefully reveals in her construction of her drug addiction as a response to trauma.

My final chapter returns us to the contemporary moment and current visibility of the white, middle-class addicted woman in popular culture. I begin with a brief analysis of a 2003 article that appeared in the popular women's fashion and lifestyle magazine, *Glamour*. The article's lead headline, which reads, "Do I look like a DRUG ADDICT to you?," exemplifies the paradox of the visibility of the contemporary white, middle-class female addict: what makes her spectacular is the invisibility of her addiction, which is veiled by her apparent "normality."

The *Glamour* article sets up my discussion of methamphetamine-addicted women on two 2005 *Oprah* shows, "Will She Choose Life or Death? An Oprah Show Intervention" (13 May 2005), and the follow-up, "The Seventeen-Year-Old Meth Addict: Did She Quit?" (28 November 2005). Both the *Glamour* article and these *Oprah* shows relate women's drug use to the failed fulfillment of their prescribed gender roles. But the centrality of autobiographical storytelling on *Oprah* brings it generically in line with the rest of the narratives that I examine in this project. Moreover, the show's emphasis on women's personal stories and the therapeutic power with which these stories are endowed reminds the reader of one of the overarching questions of this dissertation: what must drug-addicted women say about their lives in order to be heard?

The early-twenty-first century female drug addict is almost invariably an object of therapeutic culture, conceptualized through discourses of self-help and emotion, as well as medicine and science. This chapter shows how *The Oprah Show*'s therapeutic imperative – the declared goals of self-transformation and self-empowerment – overlap with the contemporary popular therapeutic discourses of addiction and recovery. I trace shared motifs of *Oprah*'s therapeutic discourse and the popular discourses of addiction and recovery, such as the necessity of self-disclosure, the merit of autobiography, the centrality of emotion, the wounded self, and the imperative of expert intervention. I am wary of the emphasis on individual culpability that these discourses construct; like other critics, I contend that the focus on the individual depoliticizes drug addiction, erasing its socioeconomic and political contexts. But, unlike other popular culture representations of white, middle-class female drug addicts, such as the *Glamour* article, which sensationalizes the female addict, *Oprah*'s therapeutic intent and the language of therapeutics that Winfrey, the show's experts, and the guests use provide a de-stigmatizing and normalizing narrative and at least a partial resolution to women's problematic addictive behaviours.

My analysis of *Oprah*'s guests stories also reveals the centrality of dominant norms of femininity to the discourses of women's drug use and addiction. I examine three women's stories – Chantel, "the 17-year-old meth addict," and "all-around American girl," Sara, "a 24-year-old mother addicted to meth," and Michelle, a "soccer mom [also] addicted to meth" who was "living the American Dream." Each woman begins her story with the assumption that "this wasn't supposed to happen" to her; heteronormative, middle-class family life and an adherence to norms of femininity – matrimony, motherhood, and appearance – were "supposed to" preclude drug addiction. Again, these women face a paradigmatic paradox of the white, middle-class female drug addict: her addiction is a desperate violation of social and gender norms at the same time as it a "normal" condition of contemporary therapeutic culture.

Chapter One

"Behave Like a Lady": Prescriptions for the Female Drug Addict in Early-Twentieth-Century America

Waking to find herself "tied to the bed like a mad dog" (214) in the "psychopathic ward" (214) at Bellevue Hospital late in 1922, the pseudonymous young drug-addicted prostitute, O.W., endures a series of patronizing and humiliating lectures delivered by nurses and doctors in the name of treatment. As O.W. prepares to leave Bellevue for a "very exclusive sanitarium in Eastport, Connecticut" (214), she is "brought down to Dr. Grover's office for a [departing] lecture" (216). To remedy O.W.'s opiate and cocaine addiction, Dr. Grover advises O.W. to "get wise to [her]self, and behave like a lady" (216). Physicians in various institutional settings, from private sanitaria to hospitals to jails, offer O.W. similarly futile moral prescriptions to "cure" her addiction.

In this chapter, I read the first published voice of drug-addicted women in American literature (White, "Women") – that of O.W., a young prostitute whose diaries supposedly became the best-selling, *No Bed of Roses: The Diary of a Lost Soul* (1930). *No Bed of Roses* is important to this project because it was written at a historical moment when the white, middle-class female addict underwent a transformation from *solely* an object of the medical institution to *also* an object of the law. Thus, in O.W. we see for the first time the embodiment of the paradoxical conception of the white, middle-class female addict as innocently ill, inherently deviant, and intentionally criminal, a paradigmatic paradox that not only informed the concept of the female addict throughout the twentieth century, but is still discernable in today's conceptualizations of the female addict.

My analysis of *No Bed of Roses* focuses on the treatment available to O.W. and her experiences in medical institutions and treatment facilities for a number of reasons. First, reviewing treatment options for drug-addicted women in the first decades of the twentieth century provides insight into a then-nascent medical discourse of addiction and introduces many competing theories of drug addiction, the echoes of which resound throughout this dissertation. Second, O.W.'s experiences of treatment most directly represent her engagement with medical discourse, which, as I note in my Introduction, is a cultural requisite for white, middle-class addicted women who tell their personal stories of drug use and addiction. More specifically, however, I am interested in O.W.'s recollections of her experiences of treatment because they suggest that, contrary to the popular rhetoric of the time, which represented drug-addicted prostitutes as a maniacal threat to the nation, the female drug addict was a more ambivalent figure in the early twentieth century. I argue that the treatment O.W. receives at the hands of general medical practitioners and emergent addiction specialists reveals a cultural ambivalence around the female drug addict that, in turn, reflects not only the demographic and social transformation of the addict figure in the early twentieth century, but also changing gender roles and expectations. This initial ambivalence, wrapped up in concepts of femininity, ethnicity, and class, has become a historically persistent and paradigmatic feature of the white, middle-class female addict, as this dissertation shows.

This chapter begins with a description of *No Bed of Roses* and the circumstances of its publication. Despite the book's apparent popularity, there is virtually no trace of *No Bed of Roses* in the popular or literary press of the 1930s. Nor has the book attracted much attention among contemporary historians and cultural critics. The few critics that cite this now obscure book heed the publisher's promotional rhetoric and treat *No Bed of Roses* as an authentic first-person account of a young woman's "descent into drug addiction" (Palmer and Horowitz 128). The book's generic conventions, which I discuss briefly, raise questions about its authenticity, however. I see *No Bed of Roses* as a highly mediated first-person account of one woman's (O.W.'s) experiences of drug addiction in early-twentieth-century urban America. Nonetheless, the book provides important insight into cultural attitudes towards and medical treatment of the female drug addict.

The second section of the chapter describes the status of the female drug addict in the first decades of the twentieth century. As historians, most notably David Courtwright, have demonstrated, "from roughly 1895 to 1935," the typical nineteenth-century opiate addict – the middle-aged, middle- or upper-class white woman – was "supplanted by a new and radically different user" – the lower-class urban male (*Dark* 1). Part of the ambivalence towards addicted women and the contradictions in the concept of the female addict resides in this historical moment of transformation. Newly pathologized and criminalized, drug-addicted women in the early twentieth century, I suggest, also bear the legacy of the late-nineteenth-century prevalence of iatrogenic opiate addiction among middle- and upper-class women.[1] I examine how the female addict during this period of cultural transformation embodies a negotiation of nineteenth-century invisibility and tolerance and early-twentieth-century stigma and legal and moral prohibition of drug addiction.

Turning to *No Bed of Roses*, I explore O.W.'s experiences of addiction treatment in the three institutional settings that she inhabits over the course of almost two years as a self-proclaimed "doper" (284). Twice, once in 1922 and again in 1923, she enters sanitaria with earnest intentions to rid herself of her "junk" habit (275). During her first attempt at sustained treatment, O.W. unhappily finds herself confined, as she says, "in the ward with the nuts" (223) at a Connecticut sanitarium. Her addiction is treated in this first sanitarium mainly as a mental illness, as it is also in her brief but noteworthy stay at Bellevue – the second significant institutional setting. The parallel between the treatment of the insane and the inebriate reflects not only a strong psychological emphasis in the emergent formulation of addiction as a disease, but also earlier associations of women's weak nerves and delicate constitutions with opiate use and addiction. During her second sanitarium stay, which is her third institutional residency, O.W. provides the most explicit account of early-twentieth-century treatment regimes. She not only recounts in detail numerous prescribed social activities, but also outlines the principles of reduction.[2] Her descriptions and interpretations of her drug-taking behaviour and failures to attain a cure echo prevalent attitudes of the time that held the addict responsible for the failure of treatment despite installing her as the proper object of medical intervention (Berridge 155; Sedgwick 131).

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[1] "Iatrogenic" refers to addiction caused unintentionally by a physician through diagnosis or treatment. Iatrogenic addiction is used interchangeably with the term "medical addiction."

[2] As the name suggests, reduction is a treatment regime in which the patient gradually reduces her intake or dosage of the drug. The idea is to wean the addict

"The First Best-Selling Book of Drug Memoirs Written by a Woman"

First published in 1930 by The Macaulay Company (New York), *No Bed of Roses* describes itself as "the actual diaries of a prostitute and a dope fiend" (jacket). The publisher repeatedly professes that "[t]his is a true story," and refers to the book as a "rare" and "unique" "document" (Publisher's Note). According to the Publisher's Note, the book "was compiled by Marjorie E. Smith from eighteen diaries written by a woman who has come to the bitterest end possible for a human being. It is the almost day to day revelation of the mind of a prostitute – the disintegration of a soul under the influence of drugs and degradation." The publisher gives little explanation of how these diaries became a book, noting only that "Miss Smith's work consisted principally of the arrangement of material." The publisher informs us that "the diaries were not written for publication" and that fictitious names have been substituted where the publication of "real ones" would result in "much suffering" (Publisher's Note).

The book intersperses daily diary entries with extended chronological narratives. Some of the longer narratives, like the description of O.W.'s familial heritage and childhood that opens the book, suggest a rather extensive "arrangement of material." And, notably, as O.W.'s drug habit increases, the diary entries, which at the beginning of the book detail such banalities as the food O.W.

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off the drug, to recondition the body and avoid severe physical symptoms of withdrawal.

eats, the movies she sees, the clothes she buys, and the household items she cleans, are less frequent and disappear altogether by the last third of the book. The narrative becomes coherent and plot-driven, revolving around the recollection of a series of sorrows and misadventures in the life of this young female "dope fiend."

Nonetheless, readers are encouraged to treat the book as an authentic account of the life of a drug-addicted prostitute. To this end, *No Bed of Roses* includes four mimeographed pages of O.W.'s diary. The first page is a list of books O.W. read. The caption beneath the neatly hand-written list reads, "An entry in the diary showing the high types of books she read" (unpaginated; between pgs. 196 and 197). The list includes *Tess of the D'urbervilles*, *The Scarlet Letter*, *Vanity Fair*, and *Les Miserables*, to name a few. Beside the books, a month-by-month list of "the diarist's earnings during a year before dope took its effect" appears; that unspecified year (1919 or 1920), O.W. earned an impressive $6531 as a high-class prostitute. Later on in the book, "a page in the diarist's ordinary handwriting" is juxtaposed with "a page written under the influence of drugs" (unpaginated; between pgs. 259 and 260). The handwriting on the first page is, of course, quite legible and remarkably straight, whereas haphazard scribbles and dark blotches of ink characterize the hand and symbolize the mind of this woman "under the influence of drugs."

Contemporary historians who cite *No Bed of Roses* accept its claims of authenticity. William White, Stephen Kandall, and Cynthia Palmer and Michael Horowitz (the only critics I have found who mention *No Bed of Roses*) use the book as uncomplicated and unquestionable historical evidence to support narratives about the material conditions of female drug addicts' lives in 1920s America. These critics say nothing about O.W., her writing style, or the significance of the act of her writing. Nor do they discuss the fact that the book closely resembles the sensational moral tales of drug use that circulated widely during America's first drug panic in the first decades of the twentieth century.[3] Specifically, *No Bed of Roses* tells the story of "the innocent addict." Fusing the familiar "fallen woman" narrative with elements of other cultural panics about white slavery and venereal disease, "the innocent addict" story typically depicts the seduction of a young upper- or middle-class woman by a villainous urban male drug trafficker. The young woman not only becomes a degraded victim; she is also transformed into a menace to society. This is indeed the tale that *No Bed of Roses* tells.

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[3] Hollywood filmmakers had a huge hand in producing and propagating the most sensational stories of drug use and addiction. The first two decades of the twentieth century witnessed the explosive birth of what Jack Stevenson calls "drug cinema" (6) in his book, *Addicted: An Illustrated Guide to Drug Cinema*. Filmmakers cast "The Drug Menace" as the "leading movie villain – a channeling demon donning by turns the masks of Pusher, Dope Fiend, Addicted Doctor and Ruined Virgin who could always be summoned up from the depths to prey on the young, naïve and amoral poor, and in the process scare, fascinate and titillate audiences" (Stevenson 11), and make a lot of money. As Stevenson explains, "The Drug Menace was a classic social hysteria nourished by the same kind of malignant paranoia that fuelled countless morality plays about communism, homosexuality and other invisible lurking dangers that were poised, in the eyes of the authorities, to destroy individuals as well as entire societies" (12). See Stevenson's Chapter One, "Highway to Hell: The Myth and Menace of Drugs in American Cinema" for synopses of films made during the 'teens and 'twenties about drug use and addiction. *Addicted* also includes some reproductions of movie posters and stills from these films that perfectly capture their moralistic tones and sensationalism. For a comprehensive inventory of "drug cinema" titles as well as effective visuals, see Michael Starks, *Cocaine Fiends and Reefer Madness: An Illustrated History of Drugs in the Movies*.

Film was not, of course, the exclusive domain of sensational drug tales during the 1910s and '20s. Popular novels and newspapers also told stories of "The Drug Menace," which, as Marek Kohn notes, revolved overwhelmingly around women (5). Stories of drug use and trafficking linked archetypal stories of the downfall of young women with "the evil influences of other races" (Kohn 4). The intertwining of race and gender, which invariably evokes the discourse of eugenics, is evident on many paperback covers and movie posters where young, white women lay either in the arms of Chinese and other dark-skinned men or under their obviously "evil" gaze and control. See *Shaman Woman, Mainline Lady* for examples of these scenes in reproductions of novel covers and film posters and stills.

After a falling out with her stepmother, who prophetically tells O.W. that she has "a face like a criminal" (16), the seventeen-year-old O.W. runs away from her "highly respectable" (9) family in their "little Western town" (9) to various cities – first Chicago, then Jacksonville, Florida, and, finally, New York. In New York, without friends or money, but with good looks, she is lured by an older man to a party at a luxurious apartment that turns out to be a "call joint" (93). A tastefully dressed woman named Camille explains to the naïve O.W. that "men [pay] well for an evening's entertainment" (93) with beautiful women and "that this was a regular profession for girls in New York" (93). She goes on to describe how well these women live, in "fine apartments" and "beautiful dresses" (93), going out with only "the very best of society people" (93). Seduced by promises of "pretty dresses and a good time" (94), O.W. "[h]eedlessly, . . . plunge[s] downward" (94). Drugs, of course, are an inevitable part of this profession, as O.W. soon finds out. O.W. is "hounded" (146) by Dale Ford, a "drug pusher" to whom she refers as "the devil" (151), until one fateful day, O.W. reluctantly accepts some heroin to help her forget the pain of a lost love (151). Instantly, O.W. is transformed into a "dope fiend" (152). Historians fail to consider the sensational and propagandistic quality of this narrative.

In their unique collection, *Shaman Woman, Mainline Lady: Women's Writings on the Drug Experience*, editors Cynthia Palmer and Michael Horowitz insist on *No*

Bed of Roses' authenticity.[4] In fact, they describe the book as "no literary masterpiece, but unmistakably authentic" (128). How they determined the "unmistakabl[e] authentic[ity]" of *No Bed of Roses* is not clear. When I was finally able to contact Michael Horowitz via email in 2005[5], he offered this explanation in response to my query for evidence of the book's authenticity:

> We were sufficiently convinced both from the text and from a note at the front of *No Bed of Roses*, written by the publisher I think, that talked about the author and her diaries. . . . I just re-read the section we reprinted and can see where one might have some doubts as to authorship. It's very vivid and detailed writing, and it was "praised by social reformers and literary critics" (from our general intro) but it could have been written by a

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[4] *Shaman Woman, Mainline Lady* was republished in 2000 as *Sisters of the Extreme: Women Writing on the Drug Experience* by Park Street Press. The differences between the editions are largely cosmetic.

[5] I've been attempting to research the authenticity of *No Bed of Roses* since 2003. I started by looking for the Fitz Hugh Ludlow Memorial Library, the collection from which Palmer and Horowitz compiled *Shaman Woman, Mainline Lady*. They list *No Bed of Roses* in the Acknowledgements as part of the Ludlow Library holdings. *When Shaman Woman, Mainline Lady* was published in 1982, the Ludlow Library was a public collection housed in San Francisco. It is possible that the Ludlow collection includes the diaries upon *which No Bed of Roses* is based, although an "Overview of Holdings" on the William Dailey Rare Books Ltd. website does not list them. In 2003, through an email correspondence with William Dailey Rare Books, I learned that the Fitz Hugh Ludlow Memorial Library was sold to a private collector. The Ludlow collection was sold jointly by William Dailey Rare Books and Flashback Books, owned by Michael Horowitz. Horowitz also indicated in email correspondence that he "sold the collection of books that were the primary resource for *Shaman Woman, Mainline Lady*."

I am indebted to Daphne Read for discovering that Horowitz owns Flashback Books; her discovery enabled me to contact him. I suspect that he and Palmer keep relatively low profiles also because they are the parents of actress Winona Ryder, who was facing shoplifting charges and accusations of drug abuse around the time I was trying to contact them.

> ghostwriter or hack, albeit quite a versatile one. It's not exactly a "feminine voice" either. If it was written by a man, he would be another Defoe (cf. *Moll Flanders*) or Cleland (*Fanny Hill*), wouldn't he? . . . I think there is an authenticity to the descriptive style expressive of a major paranoid episode of a cocaine freak-out ("bat" – an unusual term but one definitely in use), but not necessarily the work of a prostitute who kept a diary. Both the sequel and the final volume of the trilogy I think are more in doubt and do suggest a mindset of cashing in on the bestsellerdom of the first vol. (26 June 2005)

A year earlier, I had an email exchange with a bookseller who had a copy of *No Bed of Roses* for sale on abebooks.com. In his online description, Ed Reith, proprietor of Brooklawn Books, classified the book as fiction; I asked him why. He responded with some intriguing personal details about his collection as well as some insightful information about the publisher:

> The book . . . appeared on quick scan to be right in the mainstream of 'Gentleman's Literature' of the time. Which lit. consisted mainly of treacly virtuous sentiments larded with lots and lots of smutty details. Publisher was Macaulay Company, whose catalog from the time period included titles, "Love Girl," "Sex in Civilization," "Derelict Alley," "Virginity: A Novel," "The Erratic Flame," "Venus on Wheels," and many others.
>
> I took another look at the book after I got your email, and concluded that there may or may not have been an "O.W." who actually kept a diary that fell into the author's hands, but if the diary actually existed, . . . then the author has worked it over to the point that it might as well not

> have existed. There are internal inconsistencies so numerous and glaring that I concluded I was looking at fiction. (9 May 2004)

In another email, Reith added that "the primary audience for this stuff would have been men who considered themselves to be at least one step up from the working classes" (12 May 2004). Reith prefaces this suggestion with a biographical sketch of his paternal inheritance of *No Bed of Roses*; the book belonged to his grandfather, whom he describes as a "Victorian gentleman, fairly well-to-do, and an Army officer during the 1st world war, and chief engineer and later commissioner of the Water department in NYC" (12 May 2004). Reith continues, "He would rather have appeared in public in his underwear than have been seen carrying or reading a copy of 'Police Gazette,' which was the semi-salacious periodical of the time. However, a hardcopy book, tucked away among a lot of other books, would have been okay" (12 May 2004). I cite Reith's personal story not to suggest that it unequivocally reveals *No Bed of Rose*'s readership, but to consider how the book might have been edited (or written) if Reith's grandfather was in fact representative of the intended audience. How might *No Bed of Roses* encode such an audience, and what might these gestures or characteristics suggest about the book's authenticity? Unlike many contemporary women's autobiographical stories of addiction, which encode an audience of sympathetic female readers (Felski 99) either by self-consciously addressing other addicted women or assuming an intimate tone and style, *No Bed of Roses* seems intended to titillate. Reproducing many of the day's stigmatizing representations of the "drug addict," the book, in many ways, encourages the reader to exoticize O.W. rather than to sympathize or identify with her.

While Reith's responses convinced me that my growing hunches about *No Bed of Roses* as a kind of pulp fiction were accurate, I was still curious about Palmer and Horowitz's description of the book as "the first best-selling book of drug memoirs written by a woman" (128).[6] They provide some additional information that set me on a bit of an archival adventure. They note that the book "remained in print for twenty years and spawned two successful sequels, one written by O.W.'s daughter" (128). I decided to track down the sequels, which was not difficult. Although no university or public libraries housed them, the books were readily available from online used bookstores throughout the United States.

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[6] At the end of Reith's second email, prefaced by the heading "Internal Inconsistency," he reveals that he is "acquainted with several IV drug users and, at least part-time, hookers." He suggests that, apparently by virtue of them being drug users and prostitutes, none of them could write a diary. The implication, of course, is that *No Bed of Roses* must be fiction; his personal experiences support his classification of a book published 75 years earlier. He writes, "None of them that I know have enough focus or self-awareness to write even one page of a diary. Supposing that by some supreme effort a notebook was shoplifted, and a page or two was written, the following events would have taken place before the next entry: The pen was lost, she would have been thrown out of her motel room. Someone stole all her money. The black plastic garbage bag with all her clothes in it, except for those on her back, would have been misplaced. The notebook was lost. Someone else stole all her drugs. She got arrested for solicitation. The whole idea of writing a diary was entirely forgotten" (12 May 2004). I do not want to devote much energy to analyzing this rich piece of personal exposition, but I cannot help but make a couple of remarks. The most obvious bit of irony here is that Reith takes up an authorship role in perhaps much the same way that *No Bed of Roses*' author did – with the presumption that he knows these addicts better than they can know themselves (Sedgwick 131). His tone conveys disdain for these addicts (he never says women), and, as if he hadn't made himself entirely clear to me, he concludes the email by saying, "Anyhow, most of the losers I know don't have any clue about what trouble they cause and what damage they inflict on the people around them" (12 May 2004). His contempt loudly reminded me that women still face significant cultural prohibitions when they try to tell their personal experiences of drug addiction. While Reith's sentiments may also be the expressions of personal pain, he nonetheless evoked a long history of dismissive, punitive, and patronizing attitudes towards addicted women.

The first sequel, *God Have Mercy on Me! From the Diaries of a Lost Soul* (1931), is, according to the Publisher's Note, a response to "letters [that] poured into the publisher's office from all over the country asking that more be written about O.W." It begins where *No Bed of Roses* ends, on New Year's Eve of 1924, and follows O.W. through another five years of "drunken brawls, maniacal paroxysms, poverty, disease, suffering, and raving viciousness" (inside back jacket promotional description in *No Bed of Roses*).

The final three pages of *God Have Mercy on Me!* are, for my purposes, the most valuable in the book; they depict an encounter between O.W. and a "young woman" (303) who wants to know if O.W. "ever kept diaries" (303). When O.W. responds, "that was my favorite indoor sport" (303), the young woman reveals that "she had run across three of [her] diaries . . . and she'd been hunting high and low for [O.W.] for a year" (303): "She wanted to know if I would sell them to her, and if I would give her permission to use my life story in book form" (303). After a few self-deprecating remarks ("What was of interest to people in me?" [304]), O.W. recounts, "The outcome of it was, I sold her the three books, which she already had in her possession, and she paid me for permission to use my story. Since it was a bargain day for me, I told her I had fifteen more notebooks in my room uptown, that went all through my life from the beginning up to the present time" (304). The woman, who we learn from the Publisher's Note in *God Have Mercy on Me!* is newspaper reporter Marjorie E. Smith, buys the rest of the diaries and O.W. "signs them over to [her] legally" (305).

With My Eyes Wide Open: The Story of Another Lost Soul is the second sequel to *No Bed of Roses*. Published in 1949, this is the book Palmer and Horowitz attribute to O.W.'s daughter. On the outside and inside covers, however, the accredited author of *With My Eyes Wide Open* is "the author of *No Bed of Roses* and *God Have Mercy on Me!*" The Publisher's Note in *With My Eyes Wide Open* clarifies this matter of authorship. The Note begins, "*No Bed of Roses* and *God Have Mercy on Me!* have been hailed in literary circles as classics that will live as a realistic picture of modern times. They were written by Marjorie E. Smith, a New York newspaper woman, from the actual diaries of a drug addict and prostitute. Miss Smith uncovered the diaries of 'O.W.,' while she was feature writer on the *Evening Graphic*" (5). This instance of Smith's accreditation as the author of *No Bed of Roses* certainly varies from the publisher's original characterization of the book as "a first hand account of a wasted woman" (inside jacket) and the repeated assertions that "*these are the actual diaries* of a prostitute and a dope fiend" (inside jacket; emphasis mine). The Publisher's Note in *With My Eyes Wide Open* reveals another piece of important information: "*With My Eyes Wide Open* is the story of what happened to 'O.W.'s daughter, who naively believed that 'bad blood tells.' Miss Smith, who knew this tragic sequel to 'O.W.'s' life, has again written a masterpiece of biographical reporting" (5).

This description of *With My Eyes Wide Open* and the implicit description of the previous two books as "biographical reporting" calls into the question the authenticity of *No Bed of Roses* as a woman's firsthand account of her experiences as a drug-addicted prostitute in 1920s America. I do not mean to suggest, however, that the revelation of *No Bed of Roses* as "biographical reporting" should reduce its value as an unique historical document, or, given this detail, that the book does not provide insight into cultural attitudes towards the female drug addict.

What I am pointing to here is that the narrative voice in *No Bed of Roses* is a composite voice – part young, white, middle-upper class female diary writer, part female newspaper reporter, part popular fiction writer, part propagandist. The narrator does occasionally write about the act of diary writing; about halfway through the book, for example, she remarks, "It [writing in my diary] is a sort of hobby that takes up time when I am lonely. A diary gets to be like a friend, in whom you can confide your most intimate secrets" (148). However, there are also moments in the book where shifts in voice are arguably discernable. On several occasions, for instance, the speaker makes succinct critical comments about the status of women that stand out as potential editorial interventions, by which I mean moments that might be read as Smith's journalistic voice. In one such instance, when a bored O.W. leaves business college where she's training to be stenographer and finds herself living on the streets of Chicago, she befriends a woman named Patty; O.W. recalls Patty's warnings: "she . . . said I would one day learn that the battle of life is an unfair one for a woman" (34). Patty's "motto," as O.W. recalls, was "Life owed a girl something" (37). I refer to such comments as potential editorial interventions first because these comments, and others like them about the status of women, are often attributed to people O.W. meets; these voices often read like interjections or commentary on O.W.'s situation, or more often, on her impending situation. Patty's comments intervene in or interpret O.W.'s actions and descriptions of herself as "only a helpless girl" (37). Perhaps idealistically, I imagine these kinds of concise comments about women as moments where Smith, aware of the kind of sensational story that would make the book a bestseller, stealthily snuck in social commentary.[7]

Moreover, this composite voice is a product of the political climate of the first decades of the twentieth century. While the figure of the drug-addicted prostitute played a central role in society's dramatization of illegal drug use in the early twentieth century, the voices of the women who were actually living out this drama were inaudible. I suspect, in other words, that, given the climate of social reform and cultural panic in the early part of the twentieth century, the life story of a drug-addicted prostitute could not be told any other way. A woman's first-person voice would have to be rather sensational; her story would have to include lurid details, and the plot would have to depict a predictable "fall" and an inevitably moralistic "decline" to be heard at all.

As Palmer and Horowitz tell us, *No Bed of Roses* was indeed popular, remaining in print for twenty years (128). They account for the book's popularity with a useful bit of historical context: "[*No Bed of Roses*] married the drug confession genre to the emerging modern sociological viewpoint.[8] The timing couldn't have been better: the Depression had begun, Prohibition was about to end, and the drug abuser was the new epitome of the failed American" (128). I elaborate on these historical circumstances in the next section.

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[7] While I suggest that the narrative voice is a composite voice, I refer to the narrator as O.W. for the sake of fluency.

[8] Thomas De Quincey's 1822 *Confessions of an English Opium Eater* is most often cited as the original "drug confession" that sparked a genre. There is a vast literature on De Quincey; as Hickman aptly puts it, "to begin an exploration of its resonance in the discussion of narcotics, see Althea Hayter's *Opium and the Romantic Imagination*" ("Heroin Chic" 123). For excerpts of other works that were and continue to be considered part of the "drug confession genre," refer to John Strausbaugh and Donald Blaise (eds.), *The Drug User: Documents, 1840 – 1960*, Sadie Plant, *Writing on Drugs*, Mike Jay (ed.), *Artificial Paradises: A Drugs Reader*.

The Changing Figure of the Drug Addict, 1880-1920

"The drug problem," writes historian Timothy Hickman, "entered American consciousness during a period that historians have identified as a time of cultural crisis. . . . [F]in-de-siècle cultural life was characterized by a struggle to redefine the terms of human agency in ways that made sense during a period typified by its rapid technological and economic changes" ("Double Meaning" 182). Indeed, it was during this period that the concept of "addiction" – "as a means to order and recapitulate the experience of habitual drug use" (Hickman, "Heroin Chic" 123) – came into existence. In fact, the term "addiction" "didn't become common until sometime around 1910" (Hickman, "Heroin Chic" 123). Both medical professionals and popular social commentators, however, had been warning of a "spiraling national 'drug problem'" (Hickman, "Double Meaning" 182) since the beginning of the 1870s (Courtwright, *Dark* 55).[9]

By the late nineteenth century, significant sociodemographic changes effected by increased immigration, industrialization, and urbanization contributed to growing fears over drug use (Kandall 44). Drug use and addiction were increasingly associated with urban centers, and the popular press reported links between drug use and crime (Kandall 44). In her book, *Using Women: Gender, Drug Policy, and*

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[9] Historians link both increasing rates of addiction and the increased visibility of addiction as a national problem during this period to the Civil War and the invention of the hypodermic syringe. See David Courtwright, *Dark Paradise: Opiate Addiction in America Before 1940*, especially pgs. 35-61.

Social Justice, Nancy Campbell summarizes the impact of the sociodemographic changes experienced in the U.S. during the 1910s and 1920s: "Immigration, urbanization, industrialization, and the northward migration of African-Americans precipitated white middle-class anxieties that were channeled into an array of reform projects" (Campbell 67), including the 1910 Mann Act, which regulated the so-called "white slave trade," the 1914 Harrison Act, which regulated the sale of narcotics, and, of course, Prohibition (Campbell 236).

The Harrison Act (also known as the Harrison Narcotic Act and the Harrison Anti-Narcotic Act) is particularly important not only because it effectively criminalized the addict, but also because it attempted to regulate directly (and federally) the practice of medicine (Musto 129). "Ostensibly passed as a taxation measure, with paperwork provisions to track distribution of opiates and some other drugs, [especially cocaine], the law allowed only physicians and pharmacists to dispense opium, morphine, or heroin to the public" (Acker, *Creating* 33). As Caroline Acker explains in *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control*, "drugs were no longer freely available in medications anyone could purchase; and legal supplies for recreational use were no longer available" (34).

Enforcement was initially assigned to the Treasury Department primarily because of the law's tax provisions and its focus on interstate commerce (Acker, *Creating* 34; Musto 121).[10] The Treasury Department's interpretation of the law had a significant impact on medicine, and, of course, on the addict: "Although the law did not address [the issue of maintenance] directly, the Treasury Department interpreted the legislation as prohibiting any form of maintenance" (Acker, *Creating* 34) – a procedure whereby addiction is "maintained" through continued medical administration of a drug (Acker, *Creating* 34); many private physicians, however, believed that, under the provisions of the Harrison Act, they were free to prescribe opiates entirely as they saw fit (Acker, *Creating* 35). "The Treasury Department quickly began prosecuting physicians who were believed to be prescribing opiates improperly" (Acker, *Creating* 35). As William White notes in *Slaying the Dragon: A History of Addiction Treatment and Recovery in America*, "The restrictive intent of the Treasury Department regulations and their aggressive enforcement led to legal challenges and Supreme Court decisions that dramatically changed the status of the addict in America" (113). By the early 1920s, a series of court decisions culminated in a complete denial of legal access to drugs for those addicted and "redefined the addict's status from that of patient to that of criminal" (White, *Slaying* 113).[11] White argues that the practical effect of enforcement, which saw some 3,000 physicians jailed, and another 20,000 substantially fined between 1914 and 1938

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[10] Narcotic enforcement was transferred to the newly established Federal Bureau of Narcotics, under the infamous Harry J. Anslinger, in 1930 (Musto 210; Hickman, "Heroin Chic 127). Anti-narcotic policies during Anslinger's thirty-year rein as head of the FBN were characterized by his own philosophy that "The answer to the

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problem is simple – get rid of drugs, pushers, and users. Period" (qtd. in Courtwright, Joseph, and Des Jarlais 12). For accounts of Anslinger's long career as Commissioner of the FBN and his harshly repressive and demonizing anti-narcotic policies, the echoes of which still reverberate today, see Musto, *The American Disease*, Acker, *Creating the American Junkie*, Campbell, *Using Women*.

[11] See William White, *Slaying the Dragon* for synopses of the key court decisions from 1915 to 1925. David Musto also gives a comprehensive history of the cases that challenged and altered the Harrison Act in *The American Disease: Origins of Narcotic Control*; see especially Chapter 6, "The Federal Assault on Addiction Maintenance."

(*Slaying* 114), was that physicians stopped treating their addicted patients (*Slaying* 114).

Other historians, such as Hickman, suggest that the effect of the Harrison Act on medical and cultural attitudes towards the addict was less clear-cut: "The Harrison Narcotic Act . . . carved up the addict population and divided the spoils between medical and penal authorities, who in turn reinforced each other in their pursuit of the act's goals" ("Double Meaning" 188). Hickman links this division of addicts into medical and penal categories to what he calls "the double meaning" inherent in the emergent concept of addiction itself: at play in the noun "drug addict" are two contradictory senses of "addiction" as, first, an assigned or juridical condition, and, second, as a self-willed or volitional condition ("Double Meaning" 187).[12] The Harrison Narcotic Act, Hickman argues, "affirmed the addiction concept's double meaning in that it provided a solution to the problem posed by [what Hickman calls *juridical* and *volitional* addicts]" ("Double Meaning" 187-88). Juridical addicts – those of the upper- and middle-classes who were thought to be driven to drugs by the pressures of modern society (Hickman, "Heroin Chic" 125) – were defined as innocent *patients*, which, Hickman notes, "was shown in part by their willingness to place themselves under the authority of professional medicine" ("Double Meaning" 188). Volitional addicts, on the other hand, were seen as those who chose to use drugs, and whose drug use therefore betrayed an "inner degradation, a failure to possess or to attain the self mastery necessary to maintain the proper relation between" (Hickman, "Heroin Chic" 125) him or herself and the world. These addicts came to be defined as *criminals*. The notion of volitional addiction was, as Hickman notes,

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[12] Hickman locates this discrepancy between the voluntary and the compulsive in the etymology of the word "addict." See his article, "The Double Meaning of Addiction" for a discussion of this etymology. Many discussions of the history of drug addiction begin with a similar gesture; see, for instance, Jane Lilienfield "Introduction" to *The Languages of Addiction,* as well as Janet Farrell Brodie and Marc Redfield's "Introduction" to their collection, *High Anxieties: Cultural Studies in Addiction.*

> generally reserved for those whose class, and often racial, position was deemed inferior to white, middle-class America. . . Nonwhite and demimode 'others' were supposedly free of the commercial and cultural strains of modern life and were, with few exceptions, denied an excuse for taking drugs. They were assigned a greater degree of moral responsibility for their habit than were 'juridical' addicts. ("Double Meaning" 187)

This is not say, however, that there was not confusion and conflict over who bore responsibility for the treatment of addicts during the first decades of the twentieth century (White, *Slaying* 114). Indeed, the period's polarized debates over treatment and the proliferation of addiction theories, which often crystallized the paradox of addiction as both voluntary (a vice) and compulsive (a disease), revealed significant confusion and conflict within the medical profession as well as within society more broadly.

To borrow Hickman's phrase, "the double meaning of addiction" was, therefore, "put into play within the context of the turn-of-the-century cultural crisis" ("Double Meaning" 187). What Hickman's schema of the juridical and volitional addict persuasively demonstrates is that the Harrison Act was not only a measure of criminalization; it also "reflected and enhanced . . . [a] broader medico-cultural logic" (Hickman, "Double Meaning" 185) that "suggested that state and professional authority could join together in order to meet the challenges of an interdependent modernity" ("Hickman, "Double Meaning" 185). Certainly, as White concludes, the late nineteenth and early twentieth century was "a period of drug criminalization . . . driven primarily by fear[:]

> The specter of racial violence, addicted soldiers, children falling prey to drug peddlers, drug-emboldened criminal gangs, people switching to drugs after alcohol prohibition, and foreign enemies using drugs as a weapon against America were all among the images floating in the cultural stew of the Harrison Act and its enforcement. (*Slaying* 114)

But the "intense battles for professional advancement and unification [of medicine] had an effect on the process and final form of antinarcotic legislation" (Musto 13) as well.

Against this backdrop of cultural change, a transformation of the prototypical drug addict occurred: the original addict – the white, middle- or upper-class, middle-aged iatrogenic female habitué, as she was called in the nineteenth century – was usurped by what has become the fundamental addict stereotype – the younger, lower-class, urban male with connections to the underworld (Courtwright, *Dark* 1; Kandall 44). As David Courtwright succinctly states in the introduction to his seminal work, *Dark Paradise: Opiate Addiction in America Before 1940*, "Gone was the stereotype of the addicted matron; in its place stood that of the street criminal" (1).

The Female Addict: Blurring Distinctions Between Juridical and Volitional Addiction

Thus, addicted women at the turn of the century do not fit easily into Hickman's categorization of juridical and volitional addicts. Like their male counterparts, women's status as either patient or criminal also depended on their ethnicity and class; white, upper- and middle-class women, much like today, were more likely to be seen as "ill" with the "disease" of addiction, while addicted lower-class women, including prostitutes, were subject to charges of criminal psychopathology and inherent immorality. But even addicted white, middle- and upper-class women were not regarded solely as blamelessly ill. Although addiction among these women met prevailing concepts of women as biologically and psychologically vulnerable to illness and the social pressures of the day, this norm itself rendered women "other," inferior to white, middle-class, masculine America.

Contradictions inherent in women's socially constructed gender roles complicated and blurred their status as juridical or volitional addicts. These women still bore the legacy of nineteenth-century notions of women's weakness and vulnerability, which ironically circulated alongside claims of their moral superiority (Crouse 260). "In circular reasoning," writes Jamie Crouse, "because of their biological roles, women were relegated to the home, and thus the virtues that typified a private, passive, and subservient role were claimed to be theirs innately" (261). These "distinctly feminine" virtues and women's role in the home came to be seen as evidence of women's "innately superior moral nature" (Crouse 261). Responsible for the morality of the nation's future generations *and* "considered the population least resistant to the pleasure and deterioration of narcotics by the late nineteenth century" (Campbell 68), white women appeared particularly threatened by drugs. Through their construction as a threat to white women, "drugs were coded as a threat to modern civilization" (Campbell 71). Additionally, "white women's assumed susceptibility to narcotic use was extended to the seductions of nonwhite men" (Campbell 69).

Examining visual images of drug-using women from the turn of the century, Hickman notes the prevalence of Chinese men "at least catering to, if not directly causing the corruption of white women" ("Heroin Chic" 126).[13] This scenario, he explains, "could be seen as a double threat to white America, because women were often identified as carriers of what was depicted as an essentially Chinese condition into the white, middle-class home, thus corrupting the husbands, sons, brothers, and fathers who were supposed to benefit from the true woman's domestic charms" ("Heroin Chic" 126). In other words, white women's apparent susceptibility to drugs opened the door to miscegenation, which "represented a serious threat to the white race, and by extension, to the nation, and even to civilization itself" (Carstairs 151). In this scenario, white women were alternately prey and predator. Regardless, they were viewed as responsible for reproducing addiction (Campbell 73).

In this context, two key intertwined figures of addicted white women emerged: the "opium vampire," the fashionable temptress who used her sexuality and femininity to prey on unsuspecting boys and men in order to "extend the seduction of opium to 'all grades of society'" (Campbell 68, 76), and the "white slave," the innocent woman who was victimized by unscrupulous Chinese men (Campbell 68) and, in turn, employed to spread addiction far and wide (Kohn 4).

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[13] Tales of women's enslavement to dark-skinned men and drugs were popular in Hollywood films of the 1910s. White slave traffickers were often seen wielding needles, which enslaved women not only to them, but to drugs. Silent films such as *Traffic in Souls* (1913), *White Slave Traffic* (1913), *The White Slave* (1913), and *The Great White Trail* (1917) exemplify Hollywood's lurid treatment of women's enslavement through drugs (Kandall 66).

Ultimately, the "vamp" and the "slave" coalesced in the figure of the drug-addicted prostitute, who maintained what Catherine Carstairs calls a "dual symbolism" as victim and villain (150-51). Already suspect by the late nineteenth century, the drug-addicted prostitute figured prominently in the increasingly alarmist rhetoric of drug addiction during the early twentieth century. An embodiment of the day's social evils – prostitution, drug use, venereal disease, miscegenation, eugenic decline – she also represented the dangers of an emergent, seemingly licentious femininity that allowed women, especially young women, to occupy newly active sexual, social, and economic roles (de Grazia 280). Like the "flapper," the drug-addicted prostitute represented a spectacular transgression of women's proper roles as wife and mother, the guardians of moral purity. Notably, *No Bed of Roses*' readers would recognize O.W. as a flapper; O.W. describes having her hair "bobbed" (181), wearing make-up appropriately (181), and smoking (61), three of the most popular signs of the flapper and her transgessive femininity. A conflation of the flapper and the drug-addict, the drug-addicted prostitute effectively encapsulated the social anxieties and tensions of the day (Carstairs 142).

By the early twentieth century, "American society had come to regard addiction as contrary to its own best interests" (Kandall 72). As Kandall succinctly puts it, "Drug use had no place in a country that valued action, rationality, and predictability. Addicts – viewed as enslaved, unproductive, inefficient, escapist, and self-centered – were a threat to American society" (72). Drug-addicted women became visible figures mobilized to heighten apprehension about addicts in general and enhance the perceived necessity of drug prohibition. The female addict was no longer exclusively an innocent and tragic medical addict, cloaked in secrecy and quietly tolerated by a society in which opiate use was a widespread medical practice. Even medical addicts came to exhibit "a sexual deceptiveness" (Campbell 77) that constructed them as reproducers of addiction. Addiction among white women was caused by what social commentator Sara Graham-Mulhall describes in her 1926 book *Opium: The Demon Flower* as a "morbid psychology" *and* the "modern whirl of sensational, overstrained habits of life" (qtd. in Campbell 77). Addicted women in the early twentieth century, therefore, endured cultural scrutiny of their moral culpability; their addiction unsettled the distinction between patient and criminal, juridical and volitional.

These examples of the popular rhetoric of addiction and the dichotomous vamp/slave stereotypes do not constitute the whole story, however. As I suggested at the outset, attitudes towards the female drug addict, as evidenced at least in part by addiction treatment regimes, construct an even more ambivalent figure. Part of the ambivalence evidenced in addiction treatment is a product of the period in which the transformation of the dominant addict type occurred. While the early-twentieth-century female addict may not wholly resemble her nineteenth-century predecessor, particularly in age or in social status, she nonetheless carries with her a kind of legacy of the late-nineteenth-century prevalence of iatrogenic opiate addiction among middle- and upper-class women.

Put simply, the early-twentieth-century female addict inherited a set of associations between women and drug use that interpreted women's drug-taking behaviour and addiction as a natural consequence of their sex. Although women's roles and gender expectations were changing during this period, biology remained a determining factor in the comprehension and treatment of the female addict; the medical establishment maintained that women's reproductive systems made them, in the words of late-nineteenth-century physician Dr. Henry S. Taylor, "delicate and feeble" (qtd. in Kandall 23). After all, the long-standing practice of prescribing opiates for a wide range of conditions known as "female complaints" was largely responsible for the nineteenth-century prevalence of addiction among women (Kandall 23-4). While most medical practitioners were aware of the possibility of iatrogenic addiction by the early twentieth century (Courtwright, *Dark* 50) and were increasingly "reluctant to prescribe opiates for purely symptomatic relief" (Courtwright, "Female" 167), the idea of women's biological and psychological vulnerability to illness, including addiction, persisted. Women, especially those who exemplified changing (or, to some, aberrant) femininity by pursuing activities such as employment outside the domestic sphere, were supposedly particularly susceptible to what George M. Beard called the "American disease" of neurasthenia (qtd. in Morgan 48). "The general law," wrote Beard, "is that the more nervous the organization, the greater the susceptibility to stimulants and narcotics. Woman is more nervous, has a finer organization than man, [and] is accordingly more susceptible to most of the stimulants" (qtd. in Kandall 29). Iatrogenic opiate addiction and the number of female addicts may have markedly declined by 1910 (Courtwright, *Dark* 52), but notions of women's "fragile nervous constitutions" (Courtwright, "Female" 164) as a predisposing factor to addiction endured.

The association between women's weak constitutions and addiction was taken up in the early twentieth century as part of the rhetoric of drug addiction in general. In her article, "Dope Fiends and Degenerates: The Gendering of Addiction in the Early Twentieth Century," Mara Keire argues that "the perceived femininity of addiction" constitutes a "cultural continuity [that] bridged the demographic shift and connected the medical addicts of the 1880s and 1890s to the dope fiends of the 1910s and 1920s." To Keire, the "femininity of addiction" resides simply in the fact that women constituted the majority of addicts in the latter half of the nineteenth century. More than a legacy of this statistical reality, however, the "femininity of addiction" seems to me to be an extension of the notion of women's psychological vulnerability to addiction. "Constitutional predisposition" was a central concept in the nascent disease theory of addiction (Berridge 157). Moreover, addicts' supposed "constitutional predisposition" often coincided with, or was seen as part of a hereditary predisposition to addiction (Berridge 157). As in their perception of women, medical professionals "allocated a large place to biological predestination" (Berridge 157) in the theories of addiction and in the treatment of addicts. The early-twentieth-century addict, in other words, inherited, in both medical and cultural terms, a typically "feminine" nervous constitution and a weak will.

This double inheritance is apparent in O.W.'s writings. Frustrated at her failures to establish a cure, O.W. repeatedly refers to herself as a "weak woman." After an unsuccessful attempt to go "cold turkey" on her own, she writes, "If I could only have held out longer there might have been some chance for me, but I am a weak woman. I always have been" (154). O.W.'s self-pronouncement reflects both the emergent theory of addiction as a "disease of the will" (Berridge 155) and concepts of femininity that maintained women's biologically-determined psychological deficiency.

Later on, when O.W. seeks treatment for her addiction, however, her supposed vulnerability, or "natural weakness," allows some physicians to view her as a blameless victim. This sense of blamelessness is also a legacy of the nineteenth-century female addict, whose addiction was quietly tolerated, at least until opiate addiction came to be seen as a medical crisis produced largely by the medical profession itself (Kandall 15; Morgan 38). Nineteenth-century society's tolerance of drug-addicted women and the role of the medical profession in creating the problem of addiction, especially among women, require some elaboration; they too are contributing factors to the cultural ambivalence surrounding the early-twentieth-century female addict.

As Stephen Kandall notes in *Substance and Shadow: Women and Addiction in the United States*, "during most of the second half of the nineteenth century, women addicted to opiates . . . were generally tolerated in an atmosphere of silent acceptance" (3). This "silent acceptance" was in large part a reflection of class and race privilege. Although many drug users were self-medicating working-class men and women, opium use was popularly associated with the predominantly white middle- and upper-classes throughout the nineteenth century (Berridge 49). In his 1871 book, *Opium and the Opium-Appetite*, Alonzo Calkins describes the typical opium user as "the lady of haut-ton, idly lolling upon her velvety fauteuil and vainly trying to cheat the lagging hours that intervene ere the 'clockwork tintinnabulum' shall sound the hour for opera or whist" (qtd. in Kandall 16). The female addict that Calkins imagines here hardly represents a threat to society. Her passivity, in fact; exemplifies normative femininity and the proper role of the white upper-class woman. She is little more than an ornament.[14]

While the middle-class female addict, most commonly a housewife (Courtwright, *Dark* 41), was perhaps not as visible or fantastic as her upper-class counterpart, she also maintained her proper position in society. Late-nineteenth-century physicians frequently noted the secrecy with which their female patients cloaked their habitual drug use. In his influential 1880 report, "The opium habit: A statistical and clinical lecture," Chicago physician and noted addiction authority, Charles Earle explains that female opium eaters "have done this for years without imparting their secret to their nearest friends. . . The lady I referred to as being under treatment for morphia and chloroform, took the first-named drug for four years before her husband was aware of it" (qtd. in Kandall 15). The husband's ignorance of his wife's habit is a common motif in late-nineteenth-century accounts of women's addiction.[15] This motif can be interpreted several ways. In some instances, the husband's ignorance indicates the degree of shame and guilt that many women felt about their drug use. On other occasions, physicians ascribe mendacity to this secrecy and paint a picture of a stereotypically conniving woman and a not-so-innocent female addict. Most of the time, however, the husband's ignorance of his wife's addiction suggests that women who habitually used opiates continued to fulfil their wifely and motherly duties adequately. Overall, drug-addicted women were tolerated in the nineteenth century as long as they were members of acceptable (read: white middle- or upper-class) American society (Kandall 280). That they most often maintained the performance of normative femininity also helped them remain relatively invisible and innocuous.

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[14] When the upper-class female addict's lackadaisical attitude and hedonistic posture are transferred to the urban male addict in the early twentieth century, however, his apparent disregard of the country's founding Protestant work ethic is indeed seen as a threat to the nation.

[15] Refer to Mattison, "Morphinism among women" (1898); Howard, "Some facts regarding the morphine victim" (1904); and, for a fictionalized account of one woman's secret struggle to be cured of her morphine addiction before her naval officer husband's homecoming, see Margarita Spalding Gerry's 1909 short story, "The Enemy."

Despite a series of arrests for prostitution, O.W. carries white, middle-class privilege with her into treatment institutions. Nowhere in her writings does she indicate that she revealed, or was asked to reveal, her occupation at the sanitaria or in doctors' offices. Nor does she recount any disclosure of her life as a prostitute to fellow addicts. In fact, other than to belittle herself repeatedly for her weakness, she makes no allusion during her various treatment regimes to her position as a prostitute. It is as if, upon entering treatment, particularly in the sanitaria, she regains her status as the virtuous "daughter of a respectable middle western people who had always done what was right" (O.W. 230). In part, this recuperation of her "highly respectable" (O.W. 9) social position is a reflection of the sanitarium setting. The sanitaria that O.W. attends, like most sanitaria in early-twentieth-century America, are private institutions, accessible only to those who could afford them – i.e., the middle- and upper-classes (Morgan 73; Krasnick 410). O.W.'s sanitarium stays are funded by her wealthy Uncle Guardie. Money for treatment is never an issue. As she explains to a workhouse doctor while he searches for a "real, on-the-level sanitarium" (O.W. 270) for her, "I knew Guardie cared nothing for expense" (270). When O.W. enters the sanitaria she effectively sheds her "fallen woman" status because she has the money to be there. Patients and professionals alike accord her respect based on the presumption that she is a young lady of considerable affluence and social standing. I would suggest that these assumptions too are the legacy of the late-nineteenth-century female addict and the innocuity afforded to her by her class. O.W.'s performance of class – her apparent dismissal or refusal of her status as a prostitute in favour of her former high social position – also complicates her status as a drug addict. As a prostitute in 1920s America, she necessarily occupies the lower strata of society, and her addiction poses a threat to the nation. Yet, readily rejoining the middle and upper classes in the course of addiction treatment, O.W. and her addiction no longer seem so frightening and dangerous.

One final circumstance of the prevalence of addiction among women in the late nineteenth century needs to be considered as a contribution to the ambivalence of the early-twentieth-century female addict. By the end of the nineteenth century, the medical profession recognized its role in the rise of opiate addiction (Courtwright, Dark 50). In an 1894 article entitled, "The Medical Abuse of Opium," Dr. Joseph Pierce states plainly, "We have an army of women in America dying from the opium habit – larger than our standing army. The profession is wholly responsible for the loose and indiscriminate use of the drug" (qtd. in Kandall 14). Other medical practitioners shared Pierce's condemnation of their profession. Medical Director of Boston's Municipal Court, C. Edouard Sandoz, in his 1922 "Report on Morphinism," also describes addiction as a consequence of physicians' initial ignorance and remarks on their continued role in the perpetuation of addiction:

> Physicians, not realizing the dangers of long repeated use of morphine, administered it freely and allowed their patients to take their own injections, with the result that the original relief of their sufferings was often paid for by a well-nigh unconquerable slavery. It would seem that, after the danger had been clearly recognized and emphasized by many writers of all countries, physicians would have had their eyes opened and that morphinism, as a by-product of medical treatment, ought to have disappeared. Strange as it is, such has not been the case and physicians still continue to raise new crops of morphinists. . . . [T]he carelessness of doctors in prescribing opiates to patients suffering from various illnesses is a very grave source of addiction. . . . [W]ithout dispute, . . . the rank and file of medical practitioners . . . are employing narcotics vastly in excess of what the standard text-books teach to be justified in legitimate therapeutics. . . . This state of affairs . . . implies a grave accusation against the medical profession as a whole. (22-3)

The issue of addiction became a platform in the reform efforts of the medical profession by the beginning of the twentieth century (Musto 13). As David Musto notes in his influential work, *The American Disease: Origins of Narcotic Control*, "the status of both pharmacists and physicians was less than desirable, and both suffered from weak licensing laws, meagre training requirements, and a surplus of practitioners" (13). The medical profession's recognized role in creating the addiction problem also contributed to their "less than desirable" status. Thus, when "entrepreneurial and reform-minded physicians undertook to transform their profession" (Acker 197) at the turn of the century, addiction became a "new medical specialism" (Berridge 152). The establishment of another "expert" discipline was not only confirmation of the improvement and expansion of the profession (Berridge 153), but also appeared to be evidence that the profession was finally taking responsibility for its earlier misjudgements. However, emergent disease theories of addiction, which held that addiction could be self-induced and yet also the result of hereditary defect, but was nevertheless a "doctor's proper responsibility" [Berridge 160]), also became what Virginia Berridge aptly calls "a form of collective professional self-affirmation" (161-62).

The medical profession's role in the actuation of the addiction "crisis" (Courtwright, *Dark* 50) affected the treatment and perception of the female addict in the early twentieth century. For many physicians, the treatment of women patients with opiates was a recent memory that coloured their perception of the new female addict; regardless of the cause of addiction, many physicians considered themselves obligated to treat a problem whose origins they saw as essentially medical (Kandall 50). Either with genuine intentions to right the wrong they created, or in self-service as an assertion of their institutional power, physicians increasingly considered addiction treatment (although not necessarily addiction itself) their responsibility. The relation between medicine's institutional development and the conceptualization of addiction as a disease and a vice and its impact on the treatment of the early-twentieth-century female addict will become clearer as I analyze O.W.'s experiences of treatment. For now it suffices to note that the medical profession was conscious of its role in producing the crisis of addiction as it entered the twentieth century; the memory of the prevalence of iatrogenic opiate addiction among women was a fresh one.

Curing One Woman's Vice and Disease: Experiences of Drug Addiction Treatment in *No Bed of Roses*

I turn now to *No Bed of Roses: The Diary of a Lost Soul* and O.W.'s experiences of addiction and treatment. This section begins with an overview of how O.W. narrates her addiction. I then sketch one of the dominant treatment regimes of the day. Although O.W. does not experience this treatment, her mention of the hyoscine treatment that her friends undergo evokes an useful historical context. From there, I examine O.W.'s experiences in three institutional treatment settings over the course of almost two years as a self-professed "junkie."

O.W.'s descriptions of her initiation into the "dope"[16] scene match the popular narratives of the time that cast prostitutes as both troubled "denizens of the underworld" (Stanley "Morphinism" 588) and members of the licentious "sporting class" (Sandoz 24). "I took dope a few times," writes O.W., "just to prove that I was a good sport, and to see if it might possibly add some thrill to my dreary life when I was hustling. . . . Most girls in this business use it. They claim it takes them out of the stark reality that faces them on all sides" (149). At first, O.W. finds no thrill or escape in dope, and she vows "that dope was one thing [she] would stay clear of" (149). But, distressed after the breakup of a relationship that she saw as her only chance at redemption, she accepts some heroin from Dale Ford, a man she describes as "the devil" (151). "It made me forget my troubles" (151), she explains. The next day, convinced by Dale's prophecy that she "would be stark crazy" (152) if she did not cure her "heroin hangover" (152) with "a blow of heroin" (152), she takes the drug again. She writes, "The more I fought against it – the more I told myself it was wrong – the more the craving for dope seized me. My brain seemed numb. I could think of nothing but the terrible agony tearing my arms and my legs like knife-thrusts. . . .and here I was . . . a dope fiend" (152-53).

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[16] "Dope" is used in *No Bed of Roses* to refer to all types of prohibited drugs, including cocaine, but, at the time, it most often referred to morphine and heroin. The "'dope' scene" refers to opiate use, especially and increasingly heroin.

O.W. offers various rationale for her continued use of heroin and morphine. She takes up the prostitute's discourse of drug use that she previously dismissed: "I wasn't trying to cut down on [dope] at all, because it was a relief to me after a day's work" (197), she asserts. "It made me very strong, and I needed to be. . . . Life is hard on a woman" (197). This interpretation of her drug use raises issues of voice that I mentioned at the beginning of the chapter. The connection she makes between her drug use and her status as a woman stands out in the book, and, to some degree, reads like an external voice. The voice here seems to seek to politicize women's drug use by linking it to the material realities of their lives, and, in the same gesture, resist conventional notions of women as physically and virtuously frail. Whether a moment of external, journalistic commentary or the insights of O.W. as a diarist, these comments resist dominant constructs of women's drug use as a sign of their "morbid psychology" (Graham-Mulhall qtd. in Campbell 77).

At other times, the narrator's explanations reflect more mainstream ideas of addiction. In one instance, she contests the popularly held notion that addiction is the result of "weak character" by evoking the also popular idea that the "denizens of the underworld . . . seek relief from life's trials and troubles in [morphine's] soothing embrace" (Stanley, "Morphinism" 588): "No matter how much strength of character you tell yourself you have, . . . there is always the thought in mind that one whiff of dope will relieve your agony. You know, too well, that dope will bring you sleep and forgetfulness" (199). As her habit grows, she frequently provides graphic descriptions of what she calls "the horrible tortures that dope fiends go through when they are without dope" (167). O.W. cites these "tortures" of withdrawal as a kind of justification of her habitual drug use; she needs to make a living and withdrawal makes that impossible.

Long before O.W. contemplates quitting dope, she mentions that two of her friends plan to have "a doctor and a nurse come up [to their apartment] and give them the hyacine treatment for dope" (188). O.W. says little about her friends' experiences with the "hyacine treatment." She remarks only that they "were both confident that they would be cured" (188). We find out later that her friends returned to their habits shortly after the treatment, at which point O.W. theorizes that they lacked the "courage" (199) and will-power to effect a lasting cure: "a person trying to get off dope [more than anything] needs to summon every ounce of will power" (199). Her assertion reflects dominant attitudes towards the addict as responsible for the frequent failure of treatment, even as prevalent treatment methods, such as the hyoscine treatment, emphasized the physiological origins of addiction.

According to Dr. L.L. Stanley in his 1919 article, "Treatment of Drug Addiction," "Hyoscine treatment [was] one of the best known and most effective" (369) treatments. "The Hyoscine treatment," he explains, "consists in the hypodermic injection of hyoscine hydrobromate for a period of forty-eight hours, proceeded by a week in which the patient is made to eliminate by means of cathartics, diuretics, sweat baths, massage and other means for ridding him of the poisons which have accumulated in his system for so long a time" (369-70). Like many early treatment programs, the first goal of the hyoscine treatment was "chiefly to remove opiates from the system to allow for regeneration" (Morgan 84). "The administration of hyoscine," Stanley warns, "may cause a deep sleep, or a great unrestfulness if insufficient quantities . . . are given. . . . The ideal result is to have the patient free from restlessness and presenting a drowsiness just bordering on sleep" ("Morphinism" 591). Many addicts, including O.W., complained that hyoscine made them "crazy" (Sandoz 30). "I was completely out of my mind" (*God* 143), writes O.W. in *God Have Mercy on Me!*, "It made me deathly ill" (*God* 143).

Hyoscine treatment, which basically drugged the patient into sedation, or according to some addicts, delirium, to "deaden the sensation of abrupt withdrawal" (Hamilton 123), reflected the general idea that addiction involved poisons, or, as Dr. Ernest Bishop proposed, "anti-bodies" that inhibited the normal functions of the organs, particularly the liver (Hamilton 123; Morgan 84). These "anti-bodies" had to be eliminated to allow for "regeneration" of new, healthy "anti-bodies" (Hamilton 123; Morgan 84). Then "rehabilitation" of the addict could begin (Morgan 84). In most cases, however, only the withdrawal was supervised by a physician; the "rehabilitation" was essentially left up to the addict. Needless to say, relapse rates with this kind of treatment were high: "It is a matter of experience," reported Sandoz in 1922, "that a considerable number of relapses take place a short time after the patients are discharged" (30). Physicians nonetheless continued to attribute high success rates to the hyoscine treatment. Their claims, of course, were based on the patient's completion of withdrawal. After all, in the words of James A. Hamilton, New York City Commissioner of Corrections in 1922, for addicts who really wanted to quit using, "withdrawal of the drug is a very simple matter entailing no more suffering than obtains with the breaking of any other habit, for instance, tobacco or alcohol" (124). If the addict relapsed, according to Hamilton and like-minded physicians and social commentators, it was because he or she was a "true addict," as opposed to a "mere habitué" (Hamilton 124). As Dr. Stanley argued, "One of the prerequisites in treating a morphine addict is that he be perfectly willing and even anxious to take the treatment" ("Treatment" 369).

Although O.W. does not attend Bellevue Hospital in hope of being "cured," her experiences there provide some important insights into early-twentieth-century attitudes towards the addict. Moreover, the treatment she receives at the hands of the staff at Bellevue provides a potent illustration of how morality and medicine first mixed in the reconceptualization of the addict from a medical to a "recreational" or "underworld" drug user. O.W. finds herself in "the psychopathic ward"(214) at Bellevue after "going on a [cocaine] bat" (211) that ends in violent hallucinations. She decides to consume "large quantities" (211) of cocaine in a fit of suicidal depression caused by the contemplation of her "decline" (210). Brought to Bellevue in an ambulance after the police are called to her hotel room, she is immediately "given . . . a big shot of morphine" (214). When she finally awakes the next evening, she finds herself not just in "the psychopathic ward" (214), but "at the end where the most violent cases are put" (214). "Tied to the bed like a mad dog" (214), she begins to cry. Her tears are met with derision: "the nurse on duty had no sympathy for me. She said that I was the lowest of the low, and that I should be thoroughly ashamed of myself" (214). The staff, in fact, refer to O.W. as "the pest" (216).

O.W. soon learns that "she [is] to be sent to a very exclusive sanitarium in Eastport, Connecticut" (214-5). She mentions nothing about how this decision was made or whether she had any say in the matter. Before she is discharged, she is "brought down to Dr. Grover's office for a lecture" (216). O.W. recounts the lecture:

> He said that I should get wise to myself, and behave like a lady. . . .He said that I should go home, and stay there, where someone who cared something for me would look after my welfare. He said that I shouldn't be running around loose, without a guardian. . . As I was leaving his office, he warned me that if I ever landed in Bellevue again for dope, he would send me to the insane asylum. He advised me to pull myself together, and use the brains I obviously had. (216-17)

Although I have suggested that the medical treatment of the female addict reflects culturally ambivalent attitudes towards her, the nurses at Bellevue are hardly ambivalent toward O.W.. As a nonmedical, volitional addict, O.W. is clearly the "proper object of moral opprobrium" (Courtwright, *Dark* 126). The Bellevue staff recognize O.W.'s psychosis instantly as a drug overdose, which marks her as a volitional addict. Nonmedical, volitional addicts – "harlots, . . . their pimps, and criminally inclined persons of all kinds" (Smith qtd. in Courtwright, *Dark* 124) – constituted the "clear majority" of addicts in New York City as early as 1917 (Courtwright, *Dark* 124). As the so-called underworld addict emerged to replace the medical addict as a majority, "an increasing number of physicians and public health officials came to view addiction as a manifestation of psychopathy or some other serious personality disorder, to support mandatory institutionalization of addicts, and to refuse to supply addicts . . . with drugs" (Courtwright, *Dark* 126). The treatment O.W. receives at Bellevue illustrates this stigmatizing explanation of addiction as psychopathology and demonstrates the inflection of supposedly objective medical science with established morality.

Of course, O.W.'s violent behaviour and psychosis readily enable the staff at Bellevue to treat her as they would treat the "insane." In this instance, her drug-induced behaviour is easily conflated with mental illness, and, in some ways, it is unremarkable that she is restrained and placed in "the psychopathic ward" (214). On the other hand, the conflation of addiction and mental illness in treatment methods also reflects punitive cultural attitudes towards the new addict. The underworld addict, although not classifiable as fully insane, definitely lacked some kind of "normal" ethical brain function that caused him or her to deviate from generally accepted norms of thought and conduct (Berridge 157). This is not to say that the new addict was simply someone whose moral faculties had been undermined or impaired by continued use of opiates, as the inebriety theorists held before about 1920 (Acker, "Stigma" 199; Courtwright, *Dark* 133). This addict, rather, was thought to be cognizant of the codes she was transgressing (Courtwright, *Dark* 133). As Courtwright explains, and as the nurse's defamation of O.W. as "the lowest of the low" (214) implies, "the psychopathic addict was someone whose moral sense was hopelessly perverted in the first place, and whose rapid descent to addiction was unchecked by the slightest ethical compunction" (Courtwright, *Dark* 133).

While Dr. Grover's threat to send O.W. to "the insane asylum" (216) also reflects the theory of addiction as a manifestation of psychopathy, his lecture is most remarkable for its deferral to gender norms as a cure for O.W.'s addiction. His moral prescriptions – "behave like a lady;" "go home" to be "cared for" by a "guardian;" stop "running around loose" (216-17) – imply that, far from being physiologically-based as early-twentieth-century physicians such as Charles Terry argued (Terry 41), the real cause of women's addiction is deviation from proper gender roles. As opposed to the moral condemnation O.W. endures from the nurses at Bellevue, Grover's lecture reveals more ambiguous attitudes towards the female addict. His advice – a prescription for recovering normative femininity – suggests that women's addiction is neither a question of physiology or psychology. The pathology, rather, lies in deviation from prescribed gender roles and expectations. If O.W. can recuperate her lost femininity by reinstituting herself in the proper space of the home, where she will be cared for and where she will "behave like a lady," her addiction will no longer be a problem. Women's addiction, in other words, was seen as evidence that active involvement in the public sphere destroyed their health and contaminated their purity. The shelter they received in the home, on the other hand, could resuscitate and protect the moral virtue that drugs threatened.

These moral gendered prescriptions construct the female addict as culturally ambivalent because they do not stigmatize her outright; nor do they entirely absolve her of blame. The reliance on gender constructs, rather, allows medical professionals and society alike to circumvent not only scientific questions of addiction's etiology, but also any attempt at a wider understanding of the social and environmental causes of women's addiction. At the same time, such prescriptions revalorize the domestic realm as women's dominion and "proper" sphere of influence since women appear to fall prey to vice in the public sphere.

O.W. leaves Bellevue convinced of the wisdom of Dr. Grover's counsel and she vows to "bring [her]self back to the straight and narrow" (217). During the train ride to the rural Eastport, Connecticut sanitarium she happily contemplates her prospects: "The fresh air seemed to revive me. . . I felt that if there was any hope left for me, I would find myself in these surroundings, and I swore that I could come back to New York a new woman" (218). Impressed with the sanitarium (218), O.W. maintains her optimism as she is "assigned to Brooks Hall" (218), a building about "three quarters of a mile away" (218) from the main buildings where the "crazy and feeble-minded people" (218) are housed. Brooks Hall, she explains, "was for dopers, drunks, people who were merely taking rest cures, and those who were almost ready to go home" (218).

Unfortunately, O.W. is placed in Brooks Hall based on the false claim that she "was not using dope at the present" (219). After a day of typical sanitarium activities such as bathing, walking in the fresh country air, and eating a nutritious meal – activities that testify to the belief that "urban-industrial tensions" (Morgan 74) caused drug addiction – O.W. finds herself "mad with pain" (220) and utterly unable to calm herself. In a fit of self-described "temporary insanity" (221), she walks out of the sanitarium in the middle of the night. "With two cops and a chauffeur for chaperones" (222), she eventually returns to the sanitarium where Miss Gray, the night nurse, greets her with a shot of morphine from her own supply (223). "Gray," writes O.W., "was always hopped up to the ears . . . and I was glad she was on my reception committee" (223). Nevertheless, because of her midnight escapade O.W. is placed "in the ward with the nuts" (223), to which she responds violently for weeks.

During her four-week stay at the sanitarium, O.W. receives little treatment aimed at curing her addiction. She sees a physician only once, again as she prepares to leave, and, again, the only antidote he offers is a lecture, another moral prescription: "He said that I was too nice a girl, and came from too good a family, to let myself go to pieces"(224). Consistent with conventional sanitarium treatment regimes, O.W. takes short walks in the country air, sits on the porch also to imbibe the fresh air, and cleans her room. She makes no mention of any maintenance or gradual reduction treatment, the latter being especially popular in sanitaria at the time (Krasnick 408). O.W. spends her last three nights at the sanitarium "up all night sewing" (225) with Nurse Gray, who supplies not only the wool, but also the morphine.

Nurse Gray's appearance as an addicted medical professional can be interpreted a couple of ways. Her presence is a historical accuracy; morphine addiction among physicians and other medical professionals was a recognized problem by the end of the nineteenth century and into the early twentieth century (Courtwright, *Dark* 41). In fact, health professionals – physicians, nurses, dentists, pharmacists – had the highest rates of addiction of any profession (Courtwright, *Dark* 41). On the one hand, then, she reveals a kind of hypocrisy in the medical institution's readiness to use drug addiction as a platform of professionalization. And there is a sense of blame for O.W.'s continued addiction implicit in the figure of Nurse Gray. Still, Gray's presence demonstrates that drug use among upper and middle classes was not a problem so long as addicts remained productive members of society. On the other hand, while O.W. describes her jovially as "not a bad gal" (223) and "the old-battle ax" (227), Gray is also represented as a devious character whose drug addiction negates the moral authority inherent in her medical position. Nonetheless, O.W. does not reject Gray's friendship or morphine: "she and I had some good times together" (227), O.W. recalls.

The most useful parts of her stay, O.W. asserts, were her talks with Dr. DuVol, a "distinguished looking Frenchman . . . [and] incurable heroin addict . . . who had been there for years" (229): "His talks did me more good than all the treatments I had used. He would reason with me, pointing out that I was a beautiful young girl, with much to learn in the world" (229). Interestingly, O.W.'s feeling that these talks helped her more than anything else echo emergent psychological and psychiatric approaches to addiction brought about by events such as the advent of psychoanalysis (Morgan 87). As H. Wayne Morgan notes in his book, *Drugs in America: A Social History, 1800-1980*, "Addicts clearly understood the need for affection and a kind of spiritual renaissance to develop what the world called 'willpower'" (73). It took a while for physicians to translate this understanding into treatment practice; advice "for the physician to encourage [the addict] and give him [sic] moral support" (Sandoz 30) was often rejected by physicians whose moralism influenced their clinical judgment (Morgan 65).

The Eastport sanitarium, then, is an example of a "business-oriented asylum" (50), as opposed to a "medically-oriented" institution (White, *Slaying* 50-1). As White explains, "the drive toward alcohol and other drug prohibition whetted America's appetite for sobriety and opened business opportunities for those who promised aid in achieving this goal" (50). While some sanitaria were progressive both in terms of scientific thought and social reform, employing the latest technology and attempting to individualize and humanize care for addicts (Morgan 73), others were simply money-making ventures.

When O.W. leaves the sanitarium, she reflects very little on her attempt to cure her addiction. She does not derogate herself for her failure or even lament her decision to take those shots with Nurse Gray. Her concern, rather, is the uncertainty of her life: "My trouble is too little money, and no practical knowledge of the world. I don't really want to lead this life." (230-31). She explicitly links these problems to the inferior position of women in society and a lack of educational and economic opportunities that such assertions of political inferiority encompass. While this moment might be read as another intrusion of an editorial, critical voice that resists the separate spheres doctrine, O.W. adds, "I could be a good and faithful wife to some man who would understand and forgive me" (230). Seeing no other option, however, she decides to return to "hustl[ing] for a living" (231).

Her first stop is Dr. Stanley's office; Stanley greets O.W. with a "big bang of morphine" (232). Despite a growing risk of persecution for supplying narcotics, even in maintenance doses to addicts, under the Harrison Act (Musto 140), Dr. Stanley regularly provides what was known as "ambulatory treatment" to young female addicts (White, *Slaying* 113). Of course, these women, including O.W., reciprocate by offering their "companionship," or, in today's more candid parlance, their sexual services. O.W. recognizes Dr. Stanley as "a skunk . . . at heart" (232), but she pursues a relationship with him in hopes of maintaining a steady supply of opiates.

Returning promptly to a routine of hustling, O.W. moves from one hotel to the next in an effort to avoid arrest. (At the time, social reformers and law enforcement were campaigning zealously against prostitution [Rosen xi]).[17] She recounts the continual struggle to pay rent and maintain her appearance with fashionable clothing as her habit grows. Within a few months, she is arrested for prostitution and jailed in a workhouse where she receives daily maintenance shots of morphine. Upon learning of O.W.'s arrest, her wealthy Uncle Guardie writes to the workhouse and requests that O.W. be "sent to a sanitarium for another cure" (270). Dr. Armour, the workhouse doctor, initially rejects the idea, saying that a sanitarium was "no fit place, as you could get all the dope you wanted there" (270), which, of course, accurately describes O.W.'s first sanitarium stay. O.W. recalls the search for a decent sanitarium: "They searched all over for a place, and I began to realize it was a hard proposition to get a real, on-the-level sanitarium, because, it seems, most of the places just want to get patients and make money off them" (270).

Eventually, she is admitted to a nearby sanitarium deemed by Dr. Armour to be "on-the-level." Filled with optimism and determination, O.W. once again contemplates her prospects in this sanitarium setting:

> My room was delightful, and I had a private bath. . . It was more like a room in a summer resort than a sanitarium. . . . Outside my window was a balcony that ran around the entire house. I pictured how comfortable it would be sitting out there in the sun every day. That was what I needed to

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[17] For a thorough account of social reformers' campaigns against prostitution during the Progressive Era, refer to Ruth Rosen's *The Lost Sisterhood.*

> restore me to health – a sun bath every morning, and a real bath in hot soapy water afterward. . . . My room was painted white, and it was spotless. . . .There was a writing desk, a nice, soft bed, and a comfortable chair. . . In such surroundings I knew there would be no excuse for me to shirk my duty to myself, and I swore that I would take this cure seriously. (272)

O.W. soon finds the place to be "very free and easy" (274); the staff is kind and friendly, the residents are amiable, and O.W. spends her days leisurely, playing games, dancing, playing the piano, and taking long hikes through the country. "Everything was good fun, and the regulations were not strict" (288), she writes. The connection she makes here between her clean, bright, and rather opulent setting and her prospects for a cure reflect middle- and upper-class privilege as well as normative constructs of health and treatment that were not usually applied or afforded to the underworld addict. Despite her position as a prostitute, O.W. has middle- and upper-class assumptions about the possibility of curing her addiction. Moreover, she sees herself as rightfully belonging here.

The emphasis on bathing, cleanliness, and order (although common in the treatment of both male and female addicts) also has, I would suggest, a particular resonance for the female addict at the time. The early-twentieth-century female addict was only newly transgressing prescribed gender roles by being an addict. Until the dominant addict type became the young lower-class urban male, women's addiction was consistent with their femininity. When O.W. enters this sanitarium in 1923, however, her addiction is seen by some, like Dr. Grover, not only as a consequence of the violation of proper female roles, but, moreover, as gender deviation itself. Spoiling their supposed purity and virtue, drug-addicted women were increasingly represented as dirty; addiction stained them. Read rhetorically, then, this emphasis in sanitarium treatment on bathing and cleanliness is also a morally redemptive measure, especially for O.W., who later describes herself in *God Have Mercy on Me!* as a "dirty prostitute": "I used to take one bath after another. I felt unclean" (*God* 26).

When O.W. first arrives at the sanitarium, she has a long chat with Dr. Farnsworth. Consistent with the moral emphasis in popular theories of addiction causation, "He ask[s O.W.'s] cooperation, and [says her] permanent cure depend[s] entirely upon [her] own effort" (275). Farnsworth's advice is typical of early-twentieth-century addiction discourse, which conceptualized addiction as both a physical disease and a vice (Acker 199). Virginia Berridge effectively explains how this mixed message translated into theories of treatment and cure: "opium eating was medicalized; but failure to achieve a cure was a failure of personal responsibility, not medical science. . . [T]he cultivation of self-control [was] part of the treatment regime. Health was equated with self-discipline. . . . The will of the patient to be cured . . . was what mattered" (156). O.W. not only readily internalizes the moralism implicit in these treatment concepts; she, in turn, draws on her experience and her own implication in this moralist rhetoric to authorize and reinforce demonizing and degrading representations of the addict. Near the end of her stay, O.W. reiterates the notion of the patient's personal responsibility for treatment failure:

> If patients weren't cured it was their own fault. Very few were cured, but that is the way with a doper. Few dopers really try to be cured. They will go to a sanitarium and swear to the high heavens they will be serious, but

> before long they are scheming and sneaking to get more than their regular shots. I know, because I am no different from the rest. I can't tell exactly why we do it, but I guess we are all weaklings, and hardly worth saving. (288)

Aside from the social and recreational activities that O.W. enjoys during her stay at this sanitarium, which themselves constitute one kind of accepted treatment, blending psychological and physical approaches and reinstilling in the wayward addict accepted social values, gradual reduction is also part of O.W.'s treatment program. Echoing dominant medical and social opinions of the day,[18] O.W. writes,

> reduction is the only effective way to establish a permanent cure. It is the hardest way, and demands plenty of real pluck. Few dopers can withstand reduction, however, as they are too weak willed. That is natural to imagine, for if they were not weak minded they would never have become dopers in the beginning. If each of us could hold out for a reduction treatment there would be no dopers. But, as it is, the country is flooded with them. (290)

O.W. considers herself among the "weak willed," "weak minded," and "scheming" addicts. She reveals, "when I first came [to the sanitarium], I lied about reduction. I lied about the number of grains I had been getting at the workhouse. . . The doctor at the workhouse only gave me about nine grains, but only once a day. At the sanitarium I got it at 9 in the morning, at noon, at 5 in the afternoon, and at 9 in the evening. For the first week my shots were so big that I became sick to my stomach" (285-86). She also notes that she acquired the "southern habit of shooting"(286) at the sanitarium: "I also knew that they should never have given me shots. I was a sniffer, and a sniffer should be cured by mouth, because it really isn't half as bad a habit as shooting. . . . The shooting at the sanitarium made me more of an addict" (286). O.W.'s narrative here demonstrates a kind of morally-inflected medical neglect. The advent of the hypodermic syringe had long been understood as a key factor in the rise of addiction (Courtwright, *Dark* 46). From the 1870s, physicians associated the use of hypodermic medication with an increased risk of addiction (Sandoz 22; Krasnick 405; Courtwright, *Dark* 47). As O.W. insinuates, the lack of adequate medical assessment of her addiction reflects dominant attitudes towards the addict that viewed her as essentially "weak willed" and immoral.

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[18] For early-twentieth-century explanation of reduction see, L.L. Stanley, "Treatment of Drug Addiction" (1919); Edouard Sandoz, "Report on Morphinism to the Municipal Court of Boston," especially Section C, "Cure" (1922); and James Hamilton, "Treatment of Drug Addiction" (1922).

Nevertheless, O.W. faithfully follows the reduction plan mapped out by the medical staff (282) and nearly achieves a cure at the sanitarium. Then, one day, Old Man Emmett, a dirty and lame elderly man (283) and "incurable addict" (283), "walk[s] into [O.W.'s] room with a loaded gun" (284). O.W. recounts the scene and its consequences:

> I held out my arm to humor him. I believed him to be a little off in the head, and that he only thought he had morphine. . . .He shot the gun into my arm, and I found out the stuff was real. I was dreadfully sorry I had taken it. When he kept coming in two or three times a day, I got to expect it. Just a little bit like that is enough to send a cure chasing quickly. A doper is always a doper, and I am no different. Here I was in the final stages of my cure, and supposed to be cut off dope. I was getting nothing at all from the drug room. But I am weak. I should have known better, too. (284)

Remembering this moment regretfully, O.W. ponders what she could have done and what could have been done for her differently:

> Imagine a woman, supposedly in the last stages of the cure, without sufficient backbone to be faithful to a vow?
>
> What sympathy can you have for a doper like me? What right have I to expect decent treatment and loyalty? . . . Yet I am always hoping I will redeem myself. . . somehow . . . sometime. . . . Yet here I was.
>
> Everyone knew I was taking dope on the side, but no one paid attention to me. At least, no one ever stopped me. They should have locked me in a padded cell, like any other lunatic, and steadfastly refused to let me have it. They should have let me rave and scream and damn them all to hell. . . but they never should have let me get my hands on one whiff of dope. If some one could have taken interest enough in me to make me behave. However, I suppose everyone has the same experiences many times over with dopers, and as I have repeatedly said no one but yourself can do anything for you. (291)

Again, she evokes the notion of the addict's essential lack of willpower as the predisposing and determining factor in addiction. On the one hand, she espouses a demeaning and demoralizing rhetoric here, particularly in her adoption of the early-twentieth-century argument for the compulsory segregation and physical confinement of addicts (Berridge 165; Courtwright, *Dark* 138). In 1920-21, Sara Graham-Mulhall and the American Medical Associated "called for the establishment of a colony system of care of narcotics addicts" (White, *Slaying* 113). What is perhaps most disturbing about her assertion that "they should have locked [her] up," is that it is couched in the rhetoric of "what's best for the addict." Although, as Courtwright points out, support for involuntary, long-term institutionalization of addicts was often born of physicians' frustration with "seeing more and more of a less and less desirable type of addict" (*Dark* 138) rather than despotism, O.W.'s suggestion – also admittedly an expression of frustration – nonetheless reflects increasingly venomous cultural attitudes towards the addict.

On the other hand, this moment might be read as a criticism of the medical establishment, as an attempt to shift the responsibility for the failure of her treatment to the medical profession. After all, she offers a blatant example of the failure of the medical profession to treat the addict as a sick person in need of supervision and care. The passage ends, however, with a reassertion of the rhetoric of individualism and individual responsibility ("no one but yourself can do anything for you" [291]), which negates any definitive criticism of the medical establishment.

While she may bear a legacy of the prevalence of iatrogenic opiate addiction among white middle- and upper-class women in the way some treatment professionals perceive her, O.W. internalizes much of the stigmatizing rhetoric of addiction that emerged with the advent of the underworld addict in the early twentieth century. She is an ambivalent figure insofar as her femininity and her apparently upper-middle-class status dominate medical professionals' constructs of her addiction. That is, for the treatment professionals who resist or reject women's changing gender roles and draw on the nineteenth-century associations between women's innate vulnerability and opiate addiction, O.W. is not an immoral and condemnable figure. Likewise, to those who read her as a member of the acceptable upper-middle class, O.W.'s addiction is a curable disease, if also a vice or manifestation of a typically feminine weakness. Although she may be not be demonized as a "dope fiend" by these professionals, their moral prescriptions do little to help her. And eventually, she comes to see her addiction as such an extreme transgression of the same constructs of femininity and class that make her an acceptable addict to some that she becomes all the more abominable to herself.

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What I find intriguing and somewhat disheartening about O.W.'s experiences of addiction treatment is their contemporary echoes. In principle, hyoscine treatment is not that different from what the medical establishment offers addicts in the twenty-first century. The emphasis on withdrawal and abstinence and the substitution of an illicit drug for a legal one are as common now as they were in nascent addiction treatment. In fact, pharmacologic therapy, as it is now called under the U.S. Drug Addiction Treatment Act of 2000 (DATA 2000), is very much in vogue (Markel 14). Similarly moralistic debates around the disease concept of addiction and addiction etiology swirl in both the medical and popular press, as we see in the next chapter, which explores the cultural utility of the late-twentieth-century disease model. The prevalent and vague argument that "addiction is both a physical and a behavioral disease" (Kleber qtd. in Markel 14) not only effectively evades, but virtually erases questions of the systemic social and environmental causes of drug addiction. Moreover, the addict is still held personally responsible for the failure of treatment even though she is now firmly entrenched as "the proper *object* of compulsory institutional disciplines, legal and medical" (Sedgwick 131). Like the treatment facilities in *No Bed of Roses*, these institutions, "without actually being able to do anything to 'help' her" (Sedgwick 131), presume to know the addict better than she can know herself "– and indeed, offer everyone in her culture who is *not* herself the opportunity of enjoying the same flattering presumption" (Sedgwick 131).

While the women's health movement of the 1970s brought some attention to the specific needs of female drug addicts, drug-addicted women in the twenty-first century still have limited treatment options (Shavelson 70-1). Moral prescriptions, like the ones O.W. receives, prevail as popular antidotes to women's drug addiction. In residential treatment for her polydrug addiction during the early 1980s, Martha Morrison, whose autobiography is the focus of the next chapter, is upbraided for her "unladylike" behaviour. Unlike O.W., who has no single, dominant concept of addiction through which to make sense of her experience, Morrison and those who treat her understand her addiction as a distinct disease; but the supposedly non-discriminatory, non-punitive, non-stigmatizing discourse of addiction-as-disease does not stop treatment professionals from prescribing "proper" femininity as an essential part of Morrison's recovery. When the white, middle-class female drug addict becomes particularly visible again in the 1960s, also a period of marked social and political change, and enters treatment in the 1980s, the refrain is remarkably similar to the one O.W. encounters some sixty years earlier: "pull yourself together, and behave like a lady."

Chapter Two

"They Say the Disease is Responsible": The Disease Concept of Addiction in Martha Morrison's *White Rabbit: A Doctor's Own Story of Addiction, Survival and Recovery*

> We treat addiction as a disease because that makes sense to us and it works. We have no need to press the issue any further than that.
> -- Narcotics Anonymous, www.na.org/bulletins/bull17-r.htm

> They say I'm "not responsible." . . . They say the disease is responsible. What B.S. -- Martha Morrison, *White Rabbit*

This chapter is broadly concerned with the cultural utility of the late-twentieth-century disease model of addiction in white, middle-class women's conceptualizations of themselves as drug addicts. Given the ubiquity of the disease concept of addiction in contemporary Western culture, it is little surprise that the women whose stories I read in this project commonly refer to their addiction as a "disease." In many instances, their use of the disease concept is minimal and unreflexive. Often through the process of recovery, they come to a characteristically uncritical acceptance of the disease concept, like the one exemplified in my first epigraph by Narcotics Anonymous. In some stories, however, women negotiate the paradoxes and complexities of the disease concept as they use it to make sense of their addictions.

In fact, the contradictions in the figure of the early-twentieth-century female addict and the cultural ambivalence towards her, in some ways, get played out again in late-twentieth-century female addicts' negotiation of the disease concept; like the emergent discourses of drug use and addiction at the beginning of the twentieth century, the late-twentieth-century disease concept also evokes Hickman's "double meaning" of addiction as a juridical and volitional condition ("Double Meaning" 187). The addiction-disease is similarly dichotomized as ontological and functionalist (also called behavioural) (Acker, "Stigma" 194), and the addict, therefore, is either a victim of the disease or stigmatized as individually culpable for it. Furthermore, constructs of femininity continue to complicate this binary as women are still regarded as biologically and psychologically vulnerable to illness, which appears to support the ontological concept of disease; on the other hand, women are still remarkably deviant as drug addicts, which locates the blame for their "disease" in their individual, conscious behaviour.

In her 1989 autobiography, *White Rabbit: A Doctor's Own Story of Addiction, Survival and Recovery,* Martha Morrison uses the disease concept as a central motif not only to explain her addiction in "scientific" or medical terms, but also to structure her life story and construct an addict identity. Like O.W., Morrison oscillates between a professional, "respectable" world and the criminal "underworld" as a white, middle-class female addict. But unlike O.W., Morrison has recourse to the disease concept as an increasingly authoritative medical model to recover her "respectable" social position.

More than the other stories collected in this project, Morrison's book follows the formulaic pattern of self-help or twelve-step narratives: the author falls into dissolution, becomes alienated from her community, "hits rock bottom," recognizes the need for help through an intervention, renounces drugs, and, with trust in a "higher power," recovers a "truer postaddiction self" (Smith and Watson 202). In the book's Preface, Morrison extends this generic formula by characterizing her story as typically sensational: "Like all tales of addiction, this is a rather flamboyant story replete with violence, crime, treachery, deceit, out-of-control sexual escapades, suicide attempts, and profound human suffering" (ix). Morrison goes on, conventionally, to catalogue her gratitude. She thanks her father-in-law, Dr. Doug Talbott, for introducing her to her husband and for "saving [her] life" (x): "His interpretations of the 'disease' . . . were the only ones that made sense to me" (x), she adds. She thanks "Alcoholics Anonymous and Narcotics Anonymous for the self-help programs they provide" (xi-ii). And then, evoking the "primary purpose" of twelve-step groups, which is "to carry [the] message to the [addict] that still suffers" ("AA Traditions"), she offers her story as "hope" for others: "I am deeply grateful for the gift of recovery and the ability and opportunity to carry this message of love and hope" (xii).

In addition to identifying herself as a committed twelve-step recovering addict who understands her addiction as a "disease," Morrison introduces herself in the Preface as "a young woman – a young woman doctor – who surreptitiously bombarded her body with . . . drugs" (ix). Morrison's authorial position as a physician – more specifically, a psychiatrist (Morrison 2) – is, in fact, what first intrigued me about her story. How, I wondered, does Morrison's authority as a medical professional, as someone deeply entrenched in the scientific, medical discourse of addiction, affect her conceptualization of herself as a drug addict? Moreover, how does the twelve-step narrative that Morrison uses to tell her life story intersect with medical(ized) concepts of addiction? The simple answer to this latter question is that twelve-step rhetoric and medical discourse meet in the disease model of addiction, both in Morrison's story and, more broadly, in cultural narratives of addiction.

This meeting is historically and culturally specific. Prompted by demographic changes in drug use during the 1960s and 70s, most notably an explosion of drug use among America's white, middle-class youth, including again "for the first time" women, and heroin addiction among returning Vietnam veterans (Musto 247; Kandall 145, 157), older stigmatizing views of addiction began to give way to notions that promoted the reintegration of addicts into acceptable social roles (Acker, "Stigma" 203). By the 1980s, addiction had been reconceptualized as a disease in which genetically inherited biochemical abnormalities in the brain and liver cause compulsive cravings and "out-of-control" behaviour (Acker, "Stigma" 202; Morrison 184; Miller and Giannini 83). This disease model of addiction not only explained drug use and abuse in dominant culture without demonizing the addict, it also accommodated white, middle-class addicts by offering them the possibility of recovery.

Having grown up and into drug use during the 1960s, Morrison, a young, white, middle-class, professional woman, exemplifies the "new" demographic of America's drug users whose drug use could not be explained by poverty or race, or culturally accepted as psychological deviance or a mark of criminality. She is, in other words, part of the population most served by the conceptual shift in the disease model. As a physician and psychiatrist, she is also part of an institution that, particularly during the 1970s and 80s, promulgated the notion of addiction-as-disease. As the disease model becomes non-punitive to accommodate a new demographic of drug addicts, Morrison enters a residential treatment program. Her story stands, therefore, at the intersection of the historical and cultural conditions that produced and witnessed a significant conceptual shift in addiction and the disease model. Thus, *White Rabbit* provides an ideal case study for examining how the newly reconceptualized, supposedly non-stigmatizing disease model of addiction operates in the narrative reconstruction of one's life as one of the late twentieth century's "new" addicts – a white, professional, female addict. Morrison's use of the disease concept also demonstrates the interconnectedness of the medical(ized) discourse of addiction-as-disease and what Robyn Warhol and Helena Michie call the "master narrative" of AA (328).

To interrogate these interconnections, I analyze Morrison's representation of class and gender in relation not only to her addict identity, but also to her position as a medical authority. What emerges in Morrison's story is a picture of the disease concept as a mechanism by which middle-class privilege and heteronormativity are maintained. Medicine and the twelve-step recovery model are both implicated in this critique, but I am most interested in how the disease concept functions to legitimize Morrison's addiction and to maintain her multiple privileged positions.

The first part of this chapter borrows from Caroline Acker's article, "Stigma or Legitimation? A Historical Examination of the Social Potentials of Addiction Disease Models," to sketch a history of the disease models of drug addiction from the late nineteenth century up to the most recent shift – "the emergence of a nonpunitive disease model" after 1970 (Acker, "Stigma" 202). I then contextualize the demographic shift in drug use that encouraged the reconceptualization and popularization of the disease concept in the 1970s and 80s. Finally, I turn to *White Rabbit* and analyze Morrison's use of the disease concept to reconstruct her identity as a white, middle-class, female addict and addicted physician within the twelve-step "master narrative."

A History of Disease Models of Addiction

In "Stigma or Legitimation?" Acker traces shifts in the formulation of opiate addiction as a disease alongside the changing cultural utility and social implications of these disease models. She identifies three distinct "phases in the evolution of opiate addiction disease models" in the United States since about 1900:

> Before about 1920, a diversity of views regarding the nature of opiate addiction as a scientific or medical phenomenon coexisted and competed. By the mid-1920s, the groundwork had been laid for an official and scientific consensus that addiction represented a medical condition that warranted criminal justice management. After about 1970, profound changes in drug use patterns created the setting for the emergence of a nonpunitive disease model of addiction. ("Stigma" 194)

The diversity of views on the nature of drug addiction as a medical condition, which characterized the late nineteenth- and early twentieth-century discourse of addiction, was partially a product of a concurrent transformation of medicine and the medical profession. During the late nineteenth and early twentieth centuries, bacteriologists and public health workers developed knowledge about infectious diseases that resulted in declining morality rates from epidemic diseases like cholera and chronic diseases like tuberculosis (Acker, "Stigma" 197). "In the same period," Acker notes, "entrepreneurial and reform-minded physicians undertook to transform their profession" ("Stigma" 197). The American Medical

Association (AMA), for instance, "reorganized in 1901 to become a powerful voice in the interests of the private physician" (Acker, "Stigma" 197). "Laboratory research and technological development provided the cognitive base" for medicine's professionalization efforts (Acker, "Stigma" 197). The formulation of disease entities as distinct – of their own independent reality, arising from distinct causes – not only promised standardized "control of vexing human problems," such as epidemic illness, but also formed the basis of professional prestige (Acker, "Stigma" 194, 197). As Acker explains, "The evident success of such methods and the institutional strength they gained through the reform activities of physicians and scientists suggested that biological research was the most fruitful approach to understanding disease, including opiate addiction" ("Stigma" 197).

At the same time, "the shift from an unregulated drug market to one in which the sale of opiates was banned and a pervasive stigma attached to addiction also conditioned how addiction was viewed as a disease" (Acker, "Stigma" 198). Acker summarizes the resultant competing theories: "[I]n the first decade of the twentieth century, opiate addiction was variously considered an example of inebriety (a psychiatric condition that included alcoholism), a functional disorder of disturbed physiological processes, or a moral failing including a collapse of will" (Acker, "Stigma" 198).[1] We saw versions of these theories in the previous chapter, reflected in O.W.'s perception of herself as a "dope fiend" as well as in the medical treatment she received.

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[1] In his article, "Addiction as a Disease: Birth of a Concept," William White refers to the "disease concept of inebriety" as the first disease concept. In the second half of the nineteenth century, alcohol and other drug problems were discursively and scientifically unified under the term *inebriety* (White, "Addiction"). Around 1860, a multi-branched profession that specialized in the treatment of alcohol, opium, morphine, cocaine, chloral, and ether inebriety emerged (White, "Addiction"). According to White, the disease concept of inebriety was the centerpiece of the medical wing of the American Association for the Cure of Inebriety (AACI). Dr.

Still, scientific research on opiate addiction during this period was characterized by the search for an ontological explanation of addiction. That is, a significant segment of medicine sought to demonstrate that addiction was a "definite physiological disease condition with definite uniform manifestations . . . and definite understandable causation" (Lasse qtd. in Acker, "Stigma" 198). "The signs and symptoms," posited early-twentieth-century researcher C.F.J. Lasse, "are as constant, uniform and recurring as those of any other disease" (qtd. in Acker, "Stigma" 198).

Other voices, which later became more culturally audible than those who believed that opiate addiction was a distinct disease, postulated the vice theory. "Proponents of the vice theory argued that chronic self-administration of opiates simply represented a moral lapse" (Acker, "Stigma" 198). They called for a punitive

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Joseph Parrish, founder of the AACI, was the first to suggest that heredity provided a "moral and physical predestination" that made an alcoholic out of one person and spared the next (Parrish qtd. in White, "Addiction"). "Like Parrish, Dr. T.D. Crothers believed that the disease of inebriety had multiple causes (e.g., heredity, illness, emotional excitement, adversity), presented itself in quite varying patterns (e.g., chronic, intermittent), and required highly individualized treatments. What Crothers considered the 'disease' was the 'constitutional proclivity, or neurosis' that fueled excessive alcohol and other drug use. Crothers believed that such proclivity often had a physical source and manifested itself in a morbid appetite that ignited the manic pursuit of intoxication" (White, "Addiction"). Parrish and Crothers saw the disease concept of inebriety as the foundation of the movement to treat inebriety medically and to garner support for specialized institutions where inebriates could be treated (White, "Addiction"). This nineteenth-century disease concept also bolstered the marketing efforts of propriety addiction cure institutes, or private institutions, much like the late-twentieth century disease concept (White, "Addiction"). White also goes on in this article to describe how the disease concept of inebriety fell out of favour.

rather than medical response to opiate addiction (Acker, "Stigma" 198). The vice theory was more readily applied to lower class users and/or visible "others." As White explains, "Eating and injecting opiates – the pattern most prevalent among affluent whites – was referred to as a disease, while the smoking of opium – a pattern associated with the Chinese – was labeled a vice" ("Addiction as a Disease").[2]

Variant theories asserted that addiction was a condition "between a vice and a disease" (Acker, "Stigma" 198). Many of these theorists believed that continued drug-taking behavior became a habit, and "that functional changes in physiology resulted from the chronic administration" of opiates (Acker, "Stigma" 198). Acker suggests that this formulation could be "restated as a description of a functionalist or behavioral disease" ("Stigma" 198); in the functionalist model, disease is understood as a "derangement of optimal, normal or healthy functioning," and is a consequence of an individual's actions, lifestyle, and relation to the natural and social environment (Acker, "Stigma" 194). Unlike its ontological counterpart, which represented the disease of addiction as a condition that befell its sufferers, this disease model placed the blame for addiction squarely on the individual. This dichotomy, and the questions it raises about culpability and responsibility, have continually fuelled debate over the social utility of the disease concept.

Although these proposed models depended on scientific observation, they were, of course, highly influenced by prevailing cultural attitudes towards addicts as human beings (Acker, "Stigma" 198); and it is during this period, as we saw in the previous chapter, that popular opinion was moving quickly away from regarding addicts as the innocent and tragic victims of overprescription or unintentional habituation. Addicts were increasingly regarded as weak-willed, morally corrupt, and often psychiatrically disturbed (Acker, "Stigma" 198). Thus, a mixed message emerged: "Addiction was a disease, but not a respectable one" (Acker, "Stigma" 199); an addict might be sick, but she still carried the stigma of addiction.

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[2] For a thorough discussion of the perception of drug addiction as a disease and its relation to race, see Timothy Hickman's "Drugs and Race in American Culture: Orientalism in Turn-of-the-Century Discourse of Narcotic Addiction."

According to Acker, a dominant disease model of addiction emerged after 1920 concurrent with punitive federal drug legislation, specifically the 1914 Harrison Anti-Narcotic Act ("Stigma" 200).[3] As I discussed in the previous chapter, socioeconomic and demographic changes at the turn of the century contributed to growing fears over drug use, and, in turn, pushed America toward a national anti-drug policy (Kandall 44). Stephen Kandall summarizes the relations between changing socioeconomic conditions and popular perceptions of drug use thusly: "The number of drug users among the black and Chinese populations was on the rise; urban addicts were beginning to outnumber rural addicts; drug use was increasingly associated with poverty; and the press began reporting links between drug use and crime more frequently" (44). The Harrison Act, which effectively criminalized the possession of opiates, reflected the nation's popular punitive attitudes towards addicts; by the 1920s, America had come to perceive drug addiction and addicts themselves as a threat to the nation (Jonnes 49). Physicians who were perceived to be prescribing opiates improperly (i.e., providing narcotics to addicts for addiction maintenance) were seen to be no less criminal than addicts themselves; they too were swiftly prosecuted, and soon became afraid to treat patients (Kandall 76; Acker, "Stigma" 201). The prosecution of physicians eliminated community-based outpatient treatment for addiction (Acker, "Stigma" 201; Kandall 85). Addicts were also vigorously prosecuted for possession of narcotics. David Musto notes that by mid-1928, violators of the Harrison Act constituted the majority of federal penitentiary inmates (184).

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[3] Refer to the previous chapter for a discussion of the Harrison Act and the socioeconomic and demographic changes that characterized turn-of-the-century America. For a comprehensive history of American domestic and foreign drug policy, refer to David Musto's *The American Disease: Origins of Narcotics Control*.

Consistent with federal policy that criminalized the possession of opiates, and thereby criminalized addiction, the post-1920 disease model of addiction further stigmatized addicts as deviants and criminals. The Public Health Service-sponsored research of psychiatrist Lawrence Kolb shaped attitudes towards addicts for much of the first half of the twentieth century (Acker, "Stigma" 201). During his tenure as a commissioned officer in the United States Public Health Service in the 1920s (Kolb vii), Kolb posited a psychiatric disease model that claimed addiction was caused by a character defect in certain kinds of people – "delinquent types," as he called them (Acker, "Stigma" 201; Courtwright, *Dark* 115). He "claimed that when normal individuals received opiates during medical treatment, they felt no pleasure, and they had no difficulty in ceasing use when medical needs no longer dictated it" (Acker, "Stigma" 201). According to Kolb, a normal person could not become addicted because drugs satisfied needs only in abnormal personalities (Morgan 131). The use of opiates for pleasure therefore indicated "an underlying personality disorder" (Acker, "Stigma" 201). "Opiates apparently do not produce mental pleasure in stable persons," wrote Kolb in 1925 (qtd. in Morgan 131). "In most unstable persons opiates produce mental pleasure during the early period of addiction. The degree of pleasure seems to depend on the degree of instability," Kolb concluded (qtd. in Morgan 131). In effect, addiction was defined as a kind of deviance (Acker, "Stigma" 201).

Kolb's stigmatizing model, or "the deviance approach" as H. Wayne Morgan describes it (131), was "developed in a period when a variety of behaviours that seemed troubling to policymakers and social and professional elites were being pathologized as categories of psychiatric disorder" (Acker, "Stigma" 201). Medical and public health models were being deployed in areas such as prison reform and asylum management "to triage troublesome individuals into the purview of social agencies for rehabilitation" (Acker, "Stigma" 201). As federal policy became more restrictive and reliant on enforcement for addiction control, and as physicians therefore continued to distance themselves from addicts as patients, "Kolb's ideas became the basis for a stigma-laden disease model of opiate addiction" (Acker, "Stigma" 202).

The punitive aspect of Kolb's psychiatric disease model was given "physical expression" in the establishment of two federal treatment facilities during the 1930s (Acker, "Stigma" 202). Lexington and Fort Worth, as they were known by their geographical namesakes, were legislated into existence by the 1929 Porter Act, "which allocated funds for the US Public Health Service to construct and operate two 'narcotic farms' . . . to house and rehabilitate addict/offenders who had been convicted of violating federal drug laws" (White, *Slaying* 122). By the late 1920s, the resources of state psychiatric facilities and state prisons were strained because of the growing number of addicts, and federal prisons were overcrowded with violators of the Harrison Act (White, *Slaying* 122); these federal "prison-hospital-sanitariums" (Jonnes 111) appeared to be part of the solution.

Although Kolb initially saw the creation of these facilities as unnecessary, he was appointed medical director of Lexington when it opened in 1935 (Morgan 132; Acker, "Stigma" 202). During his tenure at Lexington, he influentially identified "five basic classes" of drug addicts, "four of which involved," in his words, "some definite psychiatric disturbance" (Kolb 38). In Kolb's new classifications, addicts ranged from simply "hedonistic" to "mild[ly] hysterical" to "habitual[ly] criminal" and "severe[ly] psychopathic" (Kolb 39). Kolb's classifications of addicts reinforced the principles of strict law enforcement and mandatory treatment, which meant institutional confinement.

As White succinctly puts it, Lexington and the second facility in Fort Worth, Texas, which opened in November, 1938, were "as much instruments of quarantine as they were instruments of active treatment" (*Slaying* 123). Lexington was particularly infamous for its prison-like façade; it had huge steel gates and barred windows (White, *Slaying* 123).[4] As late as 1956, Dr. James Lowry, then the medical officer of Lexington, defined the facility's purpose as containing the infectious addict: "Hospitalization is a public health measure that prevents the spread of addiction by isolating the principal agent of dissemination – the narcotic addict" (Lawry qtd. in White, *Slaying* 123). These institutions gave tangible form to the psychiatric disease model and its popularized representations of addicts as inherently, criminally and psychologically deviant as well as contagious. Thus, while research on the physiology of drug addiction was discouraged throughout the first half of the twentieth century, the elements for sustaining a stigmatizing disease model of opiate addiction became firmly entrenched (Acker, "Stigma" 202). By the 1940s, the psychiatric model, which "placed the etiology of problematic addiction in an individual's flaws of character structure" (Acker "Stigma" 202), held popular and institutional prominence.

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[4] In her 1961 book, *The Fantastic Lodge: The Autobiography of a Girl Drug Addict*, Janet Clark describes her stay at Lexington during the late 1950s. Lexington admitted voluntary patients ("Vols") as well as "Cons" (Clark 211), those legally sentenced; Clark voluntarily commits herself to Lexington for a "chance . . . to stay off long enough to get some kind of perspective on just what [she] was doing, and where [she] was going" (208). Her depiction of Lexington attests to its notoriously ineffectual treatment regimes, but her descriptions of the social hierarchies between the "Vols and Cons," and her observations of the psychological differences between the "medical junkies" and the "illicit junkies" (218-20) are more interesting. She also discusses relationships between women, noting that she "got sort of a reputation for being a female homosexual . . . there, strictly because [she] didn't know the rule about two women on a bed" (220). Clark also explains the psychological effects of the building. She recalls entering her assigned ward for the

The federal prison-hospitals of Lexington and Fort Worth are also significant because they "symbolized the breach between alcohol policies and policies related to other drugs" (White, *Slaying* 123). As White explains, "In the late 1930s,

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first time: "I had no idea that it was as much a jail as it is. There's nothing you can do, psychologically, to make bars not look like bars" (211).

Clark demonstrates an incredibly astute understanding of the effect of institutional structures on her material reality and her psychology as a female addict. As a regular patient of psychoanalysis, she engages explicitly with emergent psychological and psychiatric theories of the time to understand not only her addiction, but also addiction as a cultural phenomenon, particularly in the 1950s jazz scene, of which she was a part. Furthermore, her book is noteworthy because it is the transcription of recorded interviews she had with sociologist Howard S. Becker, whose theories of deviance and drug use became influential during the 1960s. (Becker is perhaps best known for his 1963 book, *Outsiders: Studies in the Sociology of Deviance*). Anthropologist Helen MacGill Hughes, who edited *The Fantastic Lodge*, explains in the Preface that Clark "told her story to the young man [Becker] as to a social equal" (viii). An example of the expanding reach of sociology in addiction research at mid-century, Clark's story engages with many of the psychiatric and pharmacological formulations of addiction in this period, but also exposes the material consequences of these ideas.

processes unfolded to redeem and mainstream the alcoholic, while the narcotic addict would be subjected to continued social isolation" (*Slaying* 123) and stigmatization. The modern version of addiction-as-disease is also partially rooted in this historical moment and its divergent views of the addict and the alcoholic; the disease concept was reinvented around this time to improve the public image of alcoholics and to obtain more humane treatment and public health resources for those with alcohol-related problems (Ford 152). Indeed, "The modern form of the concept of addiction as an uncontrollable disease did not appear originally with narcotics," notes Stanton Peele, "but with alcohol" ("Cultural Concept").

I want to take a moment to step outside of the historical map that Acker provides and briefly explore the evolution of the disease concept during what historians call "the modern alcoholism movement" (White, "Rebirth"), which arguably began with the founding of Alcoholics Anonymous in 1935 (coincidently the same year that Lexington opened).[5] The popularization of alcoholism-as-disease around mid-century affected, and, in some ways, effected the late-twentieth-century shift towards the nonpunitive disease model of addiction. This section offers a sketch of how the growing acceptance of the disease concept of alcoholism influenced the conceptualization of drug addiction, and addiction in general, as a disease.

In his article, "The Rebirth of the Disease Concept of Alcoholism in the 20th Century," White challenges the popular belief that Alcoholics Anonymous is "the source" of the modern disease concept of alcoholism. In White's account, "When

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[5] For a thorough history of the Modern Alcoholism Movement, see White's *Slaying the Dragon*, especially Section 5: "AA and the Modern Alcoholism Movement."

AA co-founder Bill Wilson asked Dr. Bob Smith, AA's other co-founder, to comment on the accuracy of referring to alcoholism as disease . . . Smith scribbled in a large hand on a small sheet of his letterhead: 'Have to use disease – sick – only way to get across hopelessness'" ("Rebirth"). White suggests, then, that AA initially used the disease concept as a medical metaphor to convey the seriousness of problematic drinking ("Rebirth"). The organization's use of the disease concept was not a declaration of science, White argues, but statement of collective experience ("Rebirth"). According to historian Ernest Kurtz, the absence of discussions of "disease" in AA's major texts shows that the disease concept is "hardly central to the thought of Alcoholics Anonymous" (qtd. in White, "Rebirth"). Critics do agree, however, that AA members had a significant role in spreading and popularizing the notion of alcoholism-as-disease (Kurtz qtd. in White, "Rebirth"; Reinarman 313). After all, AA was (and still is) premised upon revealing a collective experience, and reaching out and providing support to other alcoholics ("carrying the message"); the disease concept was spread through AA's mechanisms of collectivity and extension (Reinarman 313).

What's more, AA grew rapidly during the late 1930s and early 1940s, opening chapters in over a half dozen of America's largest cities within a couple of years (White, *Slaying* 134-35). The extension of AA's influence was also reflected in its movement into institutional settings: "Members . . . initiat[ed] many hospital-based alcoholism treatment programs," and began organizing meetings in state psychiatric hospitals and prisons (White, *Slaying* 135).

Indeed, the disease concept of alcoholism emerged in the 1940s as an organizing construct for alcoholism treatment and a public policy slogan (White, "Rebirth"). Reinarman provides the following historical summary of the institutionalization of the disease concept via the alcoholism movement:

> In 1942, the Alcoholism Movement was founded by Marty Mann, a public relations executive and former 'drunk,' and others. By 1944, she joined with Dr. E.M. Jellinek at Yale to create an organization *whose purpose was to popularize the disease concept by putting it on scientific footing*. . . . This organization later became the National Council on Alcoholism (NCA). Their goal was to create a new 'scientific' approach that would allow them to get beyond the old, moralistic . . . battle lines of the Temperance and Prohibition period. . . . The 1942 "Manifesto" of the Alcoholism Movement clearly stated that they sought to "inculcate" into public opinion the idea that alcoholics were "sick," and therefore "not responsible" for their drinking and its consequences, and were thus deserving of medical treatment. (emphasis mine; 313)[6]

Reinarman's chronology emphasizes the social construction of the disease concept: "science was not the source of the concept," he stresses, "but a resource for promoting it" (313).

Rapping makes an analogous argument in her discussion of AA's use of the disease concept and its compatibility with medicine. Unlike White and Kurtz, Rapping does not see AA's initial use of the disease concept as solely a medical metaphor; she points out that AA co-founder Bill Wilson was treated for his drinking problem under the emergent medical theory that alcoholism was a "like an allergy" (Rapping 68; Peele, *Diseasing* 116). Wilson's physician was Dr. William Silkworth, who was "the first to treat alcoholics based on the idea that they suffered from an inbred allergy to alcohol that caused them to lose control of their drinking" (Peele, "Cultural Concept"). The implication, as Rapping and Peele among others see it, is that AA came to base the disease concept on the "Silkworth/Wilson allergy" model (Peele, "Cultural Concept"). Still, "the science" of the disease concept was far from established in the early 1940s. As it became obvious that a permanent, institutional structure was necessary to combat the social problem of alcoholism, however, medicine came forward to promote AA's configuration of the disease concept (Rapping 72). Rapping argues that

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[6] Jellinek is often cited as the father of the modern version of the disease concept. His 1960 book, *The Disease Concept of Alcoholism*, stands, as White says, as "the most widely cited . . . literary artifact of the modern alcoholism movement ("Rebirth"). For a discussion of Jellinek's work and his influence, refer to White's *Slaying the Dragon*.

> the ideas AA developed about the causes and cures of alcoholism were compatible with the values and goals of the medical profession. Doctors understandably didn't know how to "cure" alcoholism. At the same time, they were increasingly confronted by patients for whom alcoholism . . . was a key issue. The "disease model" of alcoholism popularized by AA was a godsend for medical practitioners unwilling to consider the emotional and social bases of physical ailments. . . .
>
> At the time of its adoption by AA the disease model seemed perfectly suited to the interests of those most concerned about alcoholism. It made alcoholism a medical problem and gave the powerful medical establishment reason to welcome AA, rather than fear it, as they would have been had AA's methods been strictly based on spirituality. (68)

This compatibility between AA, the disease concept, and medicine is particularly evident again during the 1970s and 80s. Like the 1930s and 40s, the 70s and 80s not only witnessed a significant increase in drug users and a corresponding growth in AA groups and members; this period is also marked by a substantial increase in government funding for addiction treatment and medical research on addiction.

While cultural attitudes towards addicts and alcoholics were divergent during the middle decades of the twentieth century, the addiction-disease concept continued to gain institutional support and cultural momentum. According to White, "Two new mid-century addiction treatment modalities influenced thinking about the application of the disease concept to drugs other than alcohol" ("Rebirth"). The first was the emergence of the therapeutic community as a treatment modality for drug addiction (White, "Rebirth")[7]. While many early

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[7] Therapeutic communities (TCs) refer to residential treatment programs known for their very specific, highly regimented, hierarchal treatment paradigms. As White explains, "In the TC addiction paradigm, the grown addict is pictured as an infant: immature, irresponsible, stupid, impulsive, and incapable of empathy with others. Treatment is conceptualized as a process of emotional maturation achieved through heightened self-awareness and self-discipline" (*Slaying* 246). Organized in caste systems, TCs resembled "a paternalistic, authoritarian family" (White, *Slaying* 247): "One moved up the hierarchy by adhering to system norms for appropriate behavior, and one was demoted for violations of those norms" (White, *Slaying* 247). For further discussion of the milieu, including a history and common criticisms of TCs, see White's *Slaying the Dragon*, especially Chapter 24: "Mid-Century Addiction Treatment: The Rise of New Approaches."

A product of a power struggle between alcoholics and addicts in an Ocean Park, California AA group during the late 1950s, Synanon was the first ex-addict-directed therapeutic community (White, *Slaying* 241), and perhaps the most infamous. White sketches the history of Synanon also in Chapter 24. In her 1971 autobiography, *The Lonely Trip Back*, Florrie Fisher provides an account of her three-year stay at Synanon during the early 1960s. Although she details some harsh treatment and rigid hierarchical relationships in Synanon, she also discusses the power of the Synanon community: "Only gradually did I begin to grasp what Chuck Dederich [founder of Synanon] was struggling to evolve: not a new treatment for addicts, but a whole new way of living which would answer the gut-level questions therapeutic communities isolated themselves from AA and NA (White, "Rebirth"), they nonetheless often incorporated the disease concept into their configuration of the addict. From the mid-to-late 1960s onwards, second- and third-generation therapeutic communities cast addiction as a "terminal disease" that "could only be arrested by sustained participation" in their specific regimes (White, *Slaying* 242). The second treatment modality that influenced the popularization of the disease model around mid-century was methadone maintenance, which "became the major approach to the treatment of narcotic addiction" (White, "Rebirth"). In both their theoretical orientations and their clinical procedures, methadone maintenance pioneers viewed opiate addiction as a metabolic disease (White, "Rebirth"). Thus, as the modern alcoholism movement continued to extend its influence into major cultural institutions, the utility of the disease concept also expanded; the groundwork for a paradigmatic shift towards a nonpunitive disease model of addiction, in its broadest terms, was being laid.

The 1960s witnessed, in Musto's words, "an astounding increase" (247) in illegal drug use. This increase was all the more "astounding" because, for the first (highly publicized) time, white, middle-class youth represented America's drug users and future addicts. This widely discussed apparent change in the user's profile occurred (once again) amid massive changes in American society (Morgan 153;

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about life" (173). She compares Dederich to "a father of a big family" (174): "[H]e loved us no matter how we acted, and knew that we would never succeed in growing up until we learned discipline, learned concern for other people, and learned to look through the self-images everyone builds around himself to the real person inside. And it is through the Synanon game that you grow up, know yourself and begin to understand people" (Fisher 174). As part of the first generation of addicts to experience Synanon and its influential treatment paradigm, Fisher documents an important transitional period in the conceptualization of the addict from a psychologically deviant person to a damaged and/or ill person.

Musto 247). As Musto explains, the 60s were characterized by "enormous growth in the wealth of the United States. . . . Funds were available not only to wage a war in Vietnam but also to fight the War on Poverty. All this productivity and money created an unparalleled market for consumer goods and anything else that promised to make a person feel comfortable, including drugs" (247). At the same time, the generation of "baby boomers" entered the demographic "most susceptible to drug use, violence, and crime – ages 15 through 24" (Musto 247). Musto puts this population shift in perspective: "Within the decade, this age group had increased by 11 million, . . . a gain of nearly 50 percent and over twice the increase that would take place in the next 10 years" (247).

Of course, this population and this period are also known for their countercultural attitudes.[8] In *Drugs in America: A Social History, 1800-1980*, Morgan characterizes the generation that came of age in the 1960s as "more self-assured and skeptical of received wisdom than its predecessors. It was eager to defy convention in order to establish an identity" (159-60). Drugs, particularly marihuana and LSD, offered identification with an "individualism based on desire for pleasure and self-exploration rather than on accepting and fulfilling reigning ideals" (Morgan 160). More broadly, in the face of domestic and foreign turmoil of the 1960s, it seemed that "the entire system of inherited American values . . . [was] on the wane" (Morgan 160). Morgan explains,

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[8] For discussions of the various elements of what is broadly termed "counterculture" and their relationship to illicit drugs, refer to Jill Jonnes, *Hep-Cats, Narcs, and Pipe Dreams*. Jonnes discusses the influence of the Beats, for example, as well as other popular cultural phenomena. Of course, the Beats constitute another area of study; see Ann Charters' collection, *Beat Down to Your Soul: What was the Beat Generation?* for a thorough overview.

> The new generation simply did not believe in them and had the leisure time and money to indulge this disbelief through drug use. . . Young people also appeared to be more present-minded than ever, less certain about future security, often alienated from the community values that had sustained their fathers through depression and war. (160)[9]

Watching counterculture evolve through media representations of war protests and gatherings such as Woodstock, older Americans saw drug use as a symbol of the rejection of traditional values and patriotism (Musto 248), which momentarily reinforced the antidrug consensus of mid-century (Morgan 165).

As new patterns of drug use among "new [or newly recognized] population groups" (Acker, "Stigma" 202) – primarily white, middle-class men and women – continued to emerge throughout the 1970s and 80s, policies and opinions changed, however (Morgan 165). Heroin-addicted Vietnam veterans of the 1970s and cocaine-addicted young, urban, white professionals of the mid 70s and early 80s (Jonnes 306), for example, presented a new and unsettling picture of addiction.[10] Addiction among dominant culture not only challenged prevailing narratives of illicit drug addiction as a problem restricted to ethnic minorities, the poor, and the otherwise deviant, it also represented a notable market opportunity in the private health care sector (Acker, "Stigma" 202).

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[9] Refer to Chapter 3 for a discussion of Susan Gordon Lydon's first-hand account of the stress and fear produced by the political turmoil during the 1960s and 70s. Lydon explicitly relates the political climate to drug use and counterculture.

[10] See Morgan, especially Chapter 8: "A New Problem" for a discussion of the influence of heroin-addicted Vietnam veterans on attitudes towards drug addiction.

Unable to accommodate the notion of such widespread "deviance" in the dominant culture and unwilling to address the sociopolitical aspects of the changing demographics of drug use, society had to reinvent drug addiction, at least as it applied to the "new" addicts. After all, these "new" addicts, otherwise "normal" and "successful" people, did not deserve to be locked up or outcast. A conceptual shift in the disease model away from the psychiatric towards the physiological and biological fit the bill.

The disease model that emerged after 1970 emphasizes the addict's "out-of-control" behaviour as a consequence of physiological reactions to repeated drug use (Acker, "Stigma" 202). In this sense, the late-twentieth-century disease model parallels earlier functionalist disease models by focusing on individual behaviour as causation. At the same time, however, this disease model cites a combination of genetic inheritance and psychological and social environment as predisposing factors of addiction (Acker, "Stigma" 202). There are elements of ontological disease models in this configuration. While this model does not conceptualize addiction as a distinct disease entity, the notion of genetic inheritance is often cited to bring it more in line with an ontological approach. That is, often the biological or physiological component is emphasized to show that the addict is not to blame for her behaviour.[11] Yet, despite a postulated physiological basis, this model stresses individual behaviours – loss of control, compulsiveness, continued drug use despite negative consequences – as diagnostic signs of the disease (Acker, "Stigma" 203). This seemingly paradoxical formulation of disease has several implications.

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[11] I would argue that the twenty-first-century disease concept of addiction is more ontological, at least in its popular and popularized scientific configurations. The increasingly dominant idea of addiction as a "brain disease," which is NIDA's guiding principle, presumes the existence of addiction independent of any particular case of illness (Volkow; NIDA "Home"). Likewise, claims of blamelessness – "it's not her fault; she suffers from the disease of addiction" – are common refrains in popular representations of addiction, particularly among white, middle- or upper-class people.

First, this model is no longer drug-specific (Acker, "Stigma" 203). The behavioural model can "include any drug associated with dependence and compulsive use" (Acker, "Stigma" 203). As Acker argues, "This description is in fact so broad, it can include any compulsive behavior, including those that do not involve taking drugs" ("Stigma" 202). Indeed, this disease model emerged concurrently in the last quarter of the twentieth century with the vast expansion of the concept of addiction to include not only any substance, but also any behaviour, and even any affect (Sedgwick 135).

The second major implication of this reconceptualized model is that the emphasis on behaviour "justifies early treatment intervention" (Acker, "Stigma" 203). In fact, the post-1970 conceptual shift coincided with what White describes as "an explosive growth of treatment programs, particularly hospital-based and private programs, which used the disease concept" ("Rebirth"), and a marked expansion in the professionalization of addiction medicine (White, *Slaying* 273).

In *The Culture of Recovery*, Elayne Rapping describes "the burgeoning addiction empire" (92) of the 1970s and 80s. By the mid-1980s, Rapping reports, "the addiction treatment industry had become a 2-billion dollar enterprise, while private treatment hospitals alone earned one billion dollars annually" (81). White similarly observes that this period was characterized by "recovery as a cultural phenomenon" (*Slaying* 277): "Addiction recovery had gone from the shameful to

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the 'chic' – something Dr. Klaus Makela referred to as more of a "lifestyle choice than the only way out of intolerable pain"' (*Slaying* 277).

The shift away from characterological to behavioural aspects in the reconceptualized disease model corresponded with, and, in some ways, facilitated the growth of the recovery industry. After all, this new configuration of addiction-as-disease emphasized that recovery was possible (Acker, "Stigma" 203). Furthermore, compulsiveness and loss of control added to this disease model the notion that "the user cannot help it" (Acker, "Stigma" 203). Conceptualized as an involuntary condition, addiction-as-disease gained legitimacy as an illness, which, in turn, granted the addict temporary exemption from his or her normal social role and responsibilities (Acker, "Stigma" 195). Thus, in this configuration, behaviours indicate the presence of addiction, but what shifts the guilt off the individual and suggests the possibility of effective treatment is the assertion of biological processes.

By 1980, this nonpunitive disease model was largely accepted by treatment professionals as well as the public (Frans 71; Peele, "Cultural Concept"). Still, as Acker points out, it did "not displace the enforcement activity directed at users of illegal drugs" ("Stigma" 194). More precisely, it did not displace enforcement activity directed at certain groups of users. While proponents of this disease model argue that it relieves the overwhelming guilt and moral stigma of living with addiction by understanding addicts as sick and unable to control an illness with which they were most likely born, this message does not apply to all addicts, as I have argued throughout this project. It has a special resonance for white, middle-class addicts, those most likely to be able to afford treatment, and those most easily "reintegrated" into society. It also fits with longstanding cultural expectations of women as biologically and emotionally vulnerable to illness.

Morrison's Addict Identity and The Social Utility of the Disease Concept

As the disease model shifts from punitive and stigmatizing to non-punitive and legitimating to accommodate (and profit from) addiction in white, middle-class America, Martha Morrison enters a treatment program at Ridgeview Institute in Atlanta for doctors with drug problems. At twenty-nine, having acquired her drug habit during "the psychedelic sixties" (Morrison 18), Morrison, a white, middle-class woman, exemplifies the new face of addiction. As such, she experiences the disease concept as simultaneously liberating and protective. She is able to use the disease concept to legitimate her experience of addiction and to construct a socially acceptable addict identity because she occupies a privileged socioeconomic position. Her representations of class, as well as gender, reveal the normative and hegemonic assumptions and functions of the disease concept.

I would like to begin with an overview of the key rhetorical strategies in *White Rabbit*, and simultaneously provide some biographical details about Morrison. After the Preface, in which Morrison identifies her story as another sensational "tale of addiction" (ix) and a narrative of twelve-step recovery, the book opens with a diary entry dated September 12, 1979. In this entry, Morrison describes an epiphany induced by her having just intravenously injected herself with 75 milligrams of pure methamphetamine hydrochloride (1):

> *I have used speed intermittently for a decade. I have been addicted psychologically in the past on several occasions. I have had my entire life fall apart as a result of this mysterious drug.*
>
> *Nine years ago [at age 17] I was under the care of a psychiatrist for eighteen months and was hospitalized in a psychiatric institution for three months*[12]*. At that time I lost everything I had because of speed – friends, family, school, job, my mind, and my dignity. I have since recovered, finished school, and earned my M.D. degree. I am a medical doctor, a practicing psychiatrist – and a good one.* (italics in original; 1-2)

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[12] Morrison gets arrested during her high school psychology exam and hospitalized instead of incarcerated (48). Fearful of Morrison, the hospital psychiatrist recommends that she be admitted to the psych ward (51). After 48 hours of coming down from speed, Morrison is released from the hospital and her parents drive her six hours to the psychiatric ward at the University of Arkansas Medical Centre (51). "I'd landed in the loony bin," writes Morrison. "Locked up. Alone. . . . I was the youngest patient ever admitted to the adult psychiatric ward at UAMC and the first drug abuser" (51-2). As a self-described "experienced con artist . . . [Morrison] play[s] the 'good little girl game' to the hilt" (52): "It took me ten days to convince the staff that I had simply fallen in with the wrong crowd" (52). On the day that she is released, she runs away from home, "drop[s] a fistful of acid and mescaline taps, [eats] some Benzedrine and Dexamyl, and smoke[s] several joints" (53). Seventy-two hours after being discharged she is readmitted to the psychiatric ward and treated for "depression, adolescent adjustment reaction, amphetamine abuse, and paranoid schizophrenia, and . . . placed on Tofranil, Thorazine, and Mellaril, . . . strong antidepressant and antipsychotic drugs" (55). Morrison is "misdiagnosed as paranoid schizophrenic" (55), which, she explains, is "common for speed addicts" (55): "[T]hey failed to diagnose correctly and comprehend that I was a junkie, not a psychotic" (55).

This diagnosis, and Morrison's entire stay in the psychiatric ward, are reminiscent of O.W.'s experience at Bellevue, where she too is treated as a dangerous psychopath. Given the almost fifty years between O.W.'s experiences and Morrison's this similarity is noteworthy. The difference, however, is that in 1970, when Morrison is institutionalized, her drug addiction is misrecognized as schizophrenia, whereas O.W.'s drug addiction is itself regarded as mental illness.

Using this diary entry, Morrison begins her story in a direct addict voice, but she is quick to multiply her subject positions and establish her authority as a medical professional. She also immediately reveals her history of what appear to be "psychological problems"; instead of undermining her credibility, as psychiatric institutionalization usually does for women, this history evokes narratives of mastery and triumph, and recovery and redemption, which anticipates the configuration of her addiction narrative.

From the position of "recovery," Morrison then analyzes her own words. Not surprisingly, she describes the addict self of her diaries using the rhetoric of twelve step recovery. She now sees "the classic grandiosity of the addict" (6) and the addict's "denial mechanism" (6) at work in her thoughts and writings. Morrison intersperses diary entries throughout her story, until she has "recovered."

During her stay at Ridgeview, Morrison "use[s letters] as a sort of a diary" (Morrison 163). Like the diary entries, the excerpted letters always embody Morrison's "active" addict self. These excerpts lend authority to her story not only because they depict first-hand experience of addiction, which is equated with expertise in recovery rhetoric, but also because they provide Morrison, as a recovered addict, psychiatrist, and addiction treatment professional, an opportunity to analyze and interpret her own addict self.

Morrison also intersperses the voices of family members and friends. Typographically set apart from Morrison's narrative voice, Morrison's parents, siblings, and friends regularly comment on significant events or append Morrison's interpretations of her behaviours. Occasionally, these comments feel oddly defensive. Morrison's parents, for example, repeatedly explain why their teenaged daughter's drug use was imperceptible to them. In other instances, Morrison's friends and her two ex-husbands seem to justify their relationships with her, expressing their adoration repeatedly. The overall effect of these interspersed various first-person voices is ambiguous. They create a more dynamic story (although not a collaborative one)[13], and they perhaps make Morrison herself a more dynamic character, but they do not fundamentally affect Morrison's narrative of addiction. The most noticeable effect of these excerpts is to remind the reader of Morrison's privileged socioeconomic position; often these voices refer to the material conditions of Morrison's life or mention her medical training.

Indeed, Morrison's medical training and her investment in medicine are often forefront. For instance, Morrison excerpts "the medical evaluations that were written during the eight days [she] was on Cottage B" (Morrison 165), "the psychiatric ward, on suicide precaution" (Morrison 162) when she entered treatment. Reproducing the titles and subheadings of each medical document, she quotes four evaluations: the "Addictive Disease Assessment," performed by attending physician, G. Douglas Talbott (165-66), which characterizes Morrison as "a street junkie" (166), and recommends "educating her about the disease of chemical dependency" (166) and involving her in AA and NA (167); a "Social History," documented by a social worker, which includes a "careful list" (167) of the drugs Morrison used from 1964 to 1981 (167-69); a "Psychiatric Consultation," which includes a diagnosis of "1. Organic brain syndrome, secondary to withdrawal, with depression. 2. Chemical dependence, polydrug" (169); and a "Psychological Evaluation," which lists the results of various standardized tests, such as the MMPI[14], and concludes that "There is evidence for a masculine identification or at least some sexual confusion" (171) – an assessment to which I will return. Morrison understands each of these evaluations as a sort of biography: "Each professional wrote up my 'life story' in great detail. . . .[T]he most interesting observations are their interpretations of my life and of my emotional and social state" (165).

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[13] In a collaborative life narrative, the individual speakers would not be specified or one speaker would be identified as representative of the group (Smith and Watson 191). "As-told-to narratives in which an informant tells an interviewer the story of her life" (Smith and Watson 191), like Janet Clark's *The Fantastic Lodge*, or ghostwritten narratives, such as *No Bed of Roses* might be, constitute collaborative narratives.

It is beyond the scope of this chapter to analyze these medical documents thoroughly and discuss their significance as biography within an autobiography of a medical professional. I cite them here, however, to illustrate not only Morrison's investment in medical discourse, but also to show how explicitly medical discourse can constitute, or at least be incorporated into, the autobiography of the white, middle-class female drug addict. Moreover, Morrison integrates the heteronormative assumptions of this medical discourse into her addict identity, as we will see. These documents are consistent with the other external voices that Morrison incorporates into her autobiography insofar as they work to legitimize Morrison's addiction as an involuntary illness and construct her as worthy of the reader's sympathy, which is also in line with the work of the disease concept in the book. The disease concept accomplishes this work also by functioning as an organizing principle of Morrison's twelve-step narrative.

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[14] The MMPI (Minnesota Multiphasic Personality Inventory) is a widely used personality test used most often to aid in diagnosing psychiatric patients. As we will see in the next chapter, the MMPI is central to Susan Gordon Lydon's recollection of trauma; although she does not remember being sexually abused by her grandfather, the MMPI repeatedly reveals personality traits associated with those who been sexually abused as young children. For a useful history and summary of the MMPI, see Cheryl Karp and Leonard Karp, "MMPI: Questions to Ask," reprinted at http://www.falseallegations.com/mmpi-bw.htm.

This suggestion that the disease model of addiction provides a narrative framework for Morrison's life story requires some clarification and discussion of the twelve-step "master narrative" (Warhol and Michie 328). Before I proceed, I need to add a word about the slippage between "AA" and "twelve-step." The articles to which I refer here analyze AA stories specifically; however, given the widespread adoption of AA by "dozens of offshoots" (Reinarman 313), including NA and other substance-related twelve-step groups, their arguments apply equally to the "addict" who participates in twelve-step recovery. Notably, Morrison attends both AA and NA meetings and identifies herself as an alcoholic and a drug addict (5). She is, as I have suggested, firmly entrenched in twelve-step rhetoric, where the disease concept shapes the narrative structure of one's life story as a recovering alcoholic/addict.

Fundamentally, AA and twelve-step etiquette require the public recital of one's story (Warhol and Michie 328). In her article, "Personal Stories: Identity Acquisition and Self-Understanding in Alcoholics Anonymous," Carole Cain explains that "Members must agree to become tellers, as well as listeners, of AA stories" (216). "Telling AA stories," Cain suggests,

> is a way of demonstrating that one has acquired the appropriate understandings. Telling an appropriate story is thus a means of gaining validation from listeners for one's AA identity, [but telling is also] a process of construction. Using the AA model and applying it to her own life, the

> drinker comes to better understand how, and why, she is an alcoholic. . . . It is [a] cognitive process. (216)

The "Twelve Steps" themselves shape these stories, providing what Warhol and Michie call a "governing teleology" (328).[15] As Warhol and Michie argue in "Twelve-Step Teleology: Narratives of Recovery/Recovery as Narrative," "a powerful master narrative shapes the life story of each recovering alcoholic, an autobiography-in-common that comes to constitute a collective identity for sober persons" (328). Put simply, AA members and twelve-steppers "learn to fit the events and experiences of their own lives into the AA story structure" (Cain 228). Reminiscent of the formula of Morrison's book that I sketched in my opening remarks, "the master narrative [or the AA story structure] is that the recovering person admitted to addiction, gained faith that a 'higher power' could provide relief if the addict were to take certain actions, and reaped the spiritual and material benefits of taking those actions within the AA program" (Warhol and Michie 328).[16] This narrative of recovery, Warhol and Michie assert, ostensibly cuts "across lines of gender, sexual preference, ethnicity, race, social class, religion and nationality" (328), and therefore "elides social and cultural differences to construct a diverse yet unified speaking position: 'we, the men and women of Alcoholics Anonymous'" (328). In other words, "The master narrative of alcoholism [and, by extension, addiction] privileges the identity of 'alcoholic'[/'addict'] over other possible identities, making identification across class, race, or gender – for example – possible, and indeed necessary" (Warhol and Michie 336).

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[15] To read the Twelve-Steps, go to http://aa.org/en_information_aa.cfm?PageID=17&SubPage=68.

[16] Also see Cain's "Personal Stories in Alcoholics Anonymous" and Vilma Hanninen and Anja Koski-Jannes' "Narratives of Recovery from Addictive Behaviors" for synopses of recovery narrative formulae.

The disease concept is integral to this master narrative in a couple of ways. As I have discussed, AA and twelve-step groups understand addiction as a "disease," although they use the term ambiguously. While, according to Kurtz, references to the disease concept in AA literature are minimal, they can be found (and they are often cited by scholars). For instance, an AA pamphlet called "Do You Think You're Different?" uses the disease concept to encourage members' requisite identification with each other. It reads: "We in AA believe alcoholism is a disease that is no respecter of age, sex, creed, race, wealth, occupation, or education. It strikes at random." Proponents of the disease concept commonly cite this notion of indiscrimination as a positive attribute because it supposedly debunks stereotypes of alcoholics and addicts as poor, urban, Black men, for example. But in the narrative structure of one's life story as an addict, the disease concept functions as a mechanism of homogenization, which not only enables the privileging of the addict identity over other identities, but also elides difference. "[B]ecause the *disease* makes no distinctions," write Warhol and Michie, "AA makes no distinctions either. Categories [of difference] are supposed to collapse under the weight of a common humanity, a common body and soul under attack" (338) – from the addiction-disease.

Yet, looking back on her initial stages of treatment, where she is especially encouraged to identify with other addicts, Morrison interprets her addiction as a disease that seems paradoxically to hinder the elision of difference and contribute to her sense of isolation and non-belonging. She writes,

> Because my disease was so malignant . . . I didn't feel that I fit into any of the groups, professional or general. I was younger than most of the other patients, . . . and I was the only female doctor in the place. The problem was even more complex because I was a strange mix of hot-shot superstar resident and bottom-line street junkie. (175)

Conventionally, the "disease" governs Morrison's thoughts and behaviour here. Oddly, however, Morrison's perception of the exceptional severity of her "disease" represents that which *separates* her from other addicts, even though she goes on to identify differences in age, gender, and class as points of disconnection.

Nonetheless, Morrison quickly finds that she "fit[s] in best, at least in the early stages of treatment, at the Narcotics Anonymous meetings . . . [among the] old hippie, street-shooting dope fiends who rode up on their fat hog motorcycles" (176). She reasons, "I'd been forging scripts, ripping off drugstores, and firing up dope for eight years before I entered med school, and I didn't feel comfortable around all these doctors, with their uppity professional bullshit. . . . I fit in better with . . . the degenerates" (175). Although she embodies the "new" addict – the white, middle-class, professional addict – she identifies herself as a "street junkie" (175) and draws on gendered and classist stereotypes of the drug addict to construct her addict identity. It is, in part, Morrison's white, bourgeois privilege that allows her to take up this rhetoric and to take on the identity of "street junkie;" she is able to identify with the "other" and still enjoy the privilege of invisibility and the possibility of recovery (Friedling 13). But in conjunction with her class and ethnic privilege, the disease concept also enables Morrison to identify, across age, class, and gender, with "the hard-core guys" (176) at NA; after three weeks in the company of these "degenerates," Morrison "begin[s] to comprehend how very ill [she] was" (176). She writes in her diary, "There is no question regarding the extent of my addiction and no other cause except my disease" (179). According to twelve-step rhetoric, this "disease," which all AA and NA members have in common, is what powerfully and unconditionally unites Morrison with the "old hippie, street-shooting dope fiends."

As Morrison's use of the possessive "my disease" suggests, "the disease" becomes "part of one's self" (Cain 214). Cain explains, "The AA member comes to see not only his drinking as alcoholic [or her drug use as pathologically addictive], but his self as an alcoholic [or her self as an addict]. . . . Alcoholism [or addiction] is not something one has, but rather, an alcoholic [or an addict] is what one is" (Cain 214). AA and twelve-step members must undergo a change in epistemology and identity or self-understanding (Cain 214-25), which is accomplished largely through the formulaic revision and retelling of their life stories via the master narrative; and, within this narrative, the disease concept gets taken up as a key component of the reconceptualized self.

Because it presumes a genetic predisposition to addiction, or in Morrison's words, "the *inherited potential* [for the brain and liver] to respond in an abnormal or allergic fashion to mood altering chemicals" (emphasis mine; 184), the disease model suggests that addiction is an always already, although invisible, condition for some. From a position of recovery, the disease concept insists on the retrospective reinterpretation of one's life as an always already addict (Warhol and Michie 355). As a subscriber to the disease concept, therefore, Morrison reinterprets even her earliest childhood behaviours as signs and symptoms of her disease and as characteristics of an addict. Early on in *White Rabbit*, for example, Morrison recounts taking her mother's prescription painkillers apart, instinctively knowing at the age of twelve to collect and ingest the potent pink balls from the capsules (19-20). She recalls her behaviour as a clear sign of the addiction to follow:

> Later I learned that this was what heroin addicts used when their drug of choice was scarce. They'd break them down and shoot them up. At the age of twelve in Fayetteville, Arkansas, I'd never heard of the expression "breaking something down," and in the early 1960s I doubt anyone in town knew much about "shooting up." But I didn't need to be shown; *I came by the urge naturally*. I didn't shoot up for quite some time, *but I had the right instinct*. (emphasis mine; 20)

Morrison chronologically recollects an array of childhood and adolescent behaviours, thoughts, emotions, and events as symptoms of the latent addiction-disease. The notion that addiction is an inherited disease thus facilitates this narrative practice. In other words, the disease concept demands recourse to the symptom, which pathologizes behaviour by encouraging "what might have been experienced as 'normal' . . . behaviour to be reinterpreted retrospectively as signs of [addiction]" (Warhol and Michie 335), and produces a prophetic addict identity. Furthermore, because addiction is popularly understood and promoted by AA and NA as a *treatable but incurable* disease, addicts remain addicts for life (Cain 214). Morrison understands that this disease has always been and will always be a part of her life, and she structures her life story and identity accordingly.

Although the disease concept is ubiquitous as the narrative framework of Morrison's life story, late in the book we learn that Morrison did not always accept the notion of addiction-as-disease. In excerpted letters that she wrote to her best friend Maggie at the beginning of her treatment, Morrison in fact emphatically rejects the disease concept:

> I have a biochemical/genetically-based disease, or so they say. Horseshit. This goes against everything I've known from the street angle, patient angle, and professionally. . . . I can't buy this disease bullshit. . . . They want me to 'surrender' to a 'higher power' – God, or whatever, they're not specific. In other words, give up the little control I've got left. What shit. . . .[H]ow could I have let this happen? They say I'm 'not responsible.' . . . They say the disease is responsible. What B.S. (159-64)

Morrison's refusal of the disease concept – based on her knowledge as a street junkie, a psychiatric patient, and a medical professional – illustrates the novelty of the concept at the time. More importantly, Morrison occupies multiple subject positions here, encapsulated in the phrase, "street angle, patient angle, and professionally." Without the disease concept governing her understanding of addiction, her addict identity is complex, a blend of knowledges, experiences, and kinds of authority associated with different classes and social roles. Furthermore, her rejection of the disease concept is inextricable from a dismissal of the twelve-step master narrative, or, more specifically, the second and third steps – coming to believe in a Higher Power and turning one's will and one's life over to that Power ("AA's Twelve Steps") – which constitute the opening sequence of the master narrative (Warhol and Michie 330-31).

Morrison's suspicions also echo critics' concerns over the utility of the disease model that emerged during the 1970s. Feminist critics find the notion of giving oneself to a "higher power" and admitting one's powerlessness especially problematic. As Charlotte Kasl points out, many women who abuse drugs do so because they feel powerless in their lives (qtd. in Berenson 68). The disease concept not only requires women to give up what they never had (Driscoll 254), but also reinforces women's internalized oppression (Berenson 78; Frans 79), thus maintaining oppressive gender roles. Moreover, the powerlessness implicit in the disease concept "erodes human capacity for taking responsibility for one's actions" (Acker, "Stigma" 193), which seems to be a key factor in Morrison's personal rejection of the disease concept as she asks, "How could I have let this happen?" Morrison not only struggles to maintain a sense of agency here; she also refuses to allow the disease concept to excuse her from taking responsibility for her problems. The erosion of social responsibility, which, as my Introduction demonstrates, is a recurring motif in the late-twentieth and early-twenty-first century discourses of addiction, leads to a reduced sense of culpability for social inequalities and institutional oppression that cause, or at least contribute to addiction (Frans 177). Simultaneously, as Acker's discussion of disease models shows, the remedy is affixed "at the level of individual intervention" (Frans 77). Although Morrison does not go as far as to characterize the disease concept as a mechanism of the depoliticization of addiction, as critics such as Douglas Frans and Claudia Bepko do, her emphasis on responsibility certainly evokes the key terms of debate over the utility of the disease concept.

Morrison's skepticism of the disease concept is short lived, however. A few weeks into her treatment program, she describes listening to a lecture on the disease concept. Morrison recounts with epiphanic zeal the moment that she comprehends addiction as a disease:

> The first time I heard Dr. Doug Talbott give the "disease concept" lecture, I was in shock. This man might as well have been telling my life story – the progression of the illness, the loss of control, the denial, the confusion, the paranoia, the guilt, the embarrassment, the withdrawal, and the terrible loneliness. He had answers to some of the "whys" that I had never understood, like why I continued to take drugs despite the horrendous consequences. (184)

When "disease" is manifest in behaviours and emotions, and when it becomes the impetus of a "life story" in which Morrison can fit the events and experiences of her life, when it evokes the master narrative, in other words, Morrison accepts the disease concept as a valid scientific explanation of her seventeen-year poly drug addiction.

Notably, however, she frames her acceptance of the disease concept as primarily a spiritual act, an act of faith required of the twelve-step recovery, but one that is intricately tied to her faith in medicine. Morrison reflects,

> Doug Talbott was not the "author," so to speak, of the disease concept, but he was one of the first doctors to adapt the concept to a treatment setting, and he was a leader in the use of the disease concept in the treatment of addicted doctors.
>
> At first I didn't believe a word of it. This concept went totally against my training as a scientist. Nevertheless, astonishing as it seemed at the time, I began to realize that doctors could be – God forbid – wrong.

> Most physicians accepted the moralistic view concerning drug addiction and alcoholism. They saw it as moral deprivation, a "weakness of character." . . . Through Talbott, I learned that addicts didn't lack willpower; they suffered from a disease.
>
> I realized that if I was going to survive this hell, I had to believe in someone. . . . Initially, Talbott became my Higher Power, the being I submitted to in the belief that he could save me. (185-86)

This passage alludes to the historical and institutional coordinates of the nonpunitive disease concept. Morrison's initial encounter with the disease concept, which is depicted here, occurs in 1980, during a period of institutionalization, political legitimation, and cultural recognition of drug addiction-as-disease. Morrison's description of Talbott's pioneering work with the disease concept and his use of it in treatment contexts situates her story at a moment of significant expansion in addiction medicine. The National Institute on Drug Abuse (NIDA) had been recently established "to lead the Nation in bringing the power of science to bear on drug abuse and addiction" (NIDA, "About NIDA"). State medical societies devoted to supporting physicians who were practicing addiction medicine were emerging, and the American Medical Association founded the American Society of Addiction Medicine (White, *Slaying* 272-3) two years after Morrison meets Dr. Talbott. And, with budgetary support from the Nixon administration and its "war on drugs" strategy, and scientific support from new medical research, therapeutic communities, like Ridgeview, were proliferating (Musto 250; Kandall 203).[17] Like the institutional structure that emerged some forty years earlier to popularize the disease concept of alcoholism by putting it on scientific footing (Reinarman 313), the institutional apparatus of the 1970s and 80s moved to popularize the disease concept of drug addiction also based on scientific research.

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[17] Nixon coined the term "war on drugs" in 1971 (Musto 248). Infamous for its emphasis on law enforcement, Nixon's "war on drugs" was actually a much more

This excerpt also illustrates a historically persistent intersection between moral and medical discourses of drug addiction, and brings us back to Rapping's comments about the compatibility between AA's use of the disease concept and medicine. Even as Morrison suggests that the disease concept marks a shift in medicine away from moralizing addiction, she grants medicine, through Talbott, absolute moral authority over her as an addict. Furthermore, this moral authority of medicine is a function of Morrison's adherence to the essential twelve-step practice of giving oneself over to a "higher power." Morrison conflates medicine and spirituality in the disease concept, and her acceptance of the disease concept depends on this fusion.

As I have suggested throughout this chapter, Morrison's socioeconomic status also facilitates her enthusiastic embrace of the disease concept. Insisting on the normality of her background from the beginning of *White Rabbit*, Morrison implies that her class necessarily precludes drug addiction. This assumption recurs throughout white, middle-class women's stories of addiction, (and is particularly fundamental to the stories of "suburban moms addicted to drugs" on *The Oprah Winfrey Show*, which I examine in my last chapter). When Morrison finally

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comprehensive strategy. The budgetary support for treatment programs was larger than the budget for law enforcement (Musto 250), although law enforcement had a more significant impact on the most marginalized drug users and arguably on popular representations of the drug addict than treatment.

recognizes herself as a drug addict, the disease concept allows her to retain the bourgeois privilege of invisibility and to maintain a socially acceptable role as a "sick" person.

Following the introductory diary excerpt of Morrison injecting herself with methamphetamine (1), Morrison describes her familial and class background. Born and raised in "Fayetteville, Arkansas, a small, relatively quiet town" (8), she recalls a childhood full of "material comforts" (9) and a "stable, happy" (9), conflict-free family life (9). She paints a quaint picture of her family: "Ours was a middle-class family of staunch southern Baptists. . . My parents were fairly well off. . . .Pillars of the community, as they say. We lived in a neat, comfortably roomy stone house on the corner of Willow and Maple Streets, on the older, better-established side of town" (9). She adds, "since my family was basically stable . . . I have no memory of suffering any severe emotional problems" (9).

Morrison's adolescence coincides with the revolutionary 60s (18), during which time she performs "a total role reversal from pep squad leader, newspaper editor, thespian, and all-around American girl to glassy-eyed scruffy-looking peace, love, and drug freak" (42). She "goes totally counterculture" (42), and accordingly rejects "all the values and morals [she] had been raised to cherish" (18).[18] Nonetheless, Morrison proceeds, as is expected of her and as she desires, to college and, obviously, eventually to medical school. Her education in particular screens her problematic drug use; Morrison reflects, "I believed that as long as I stayed in school and got good grades, everything would be alright" (42). Morrison's mother concurs: "I think the fact that she was so bright prevented us from noticing the drugs" (42). Indicative of Morrison's privileged socioeconomic background, Morrison's mother adds, "Of course, we'd never heard of drugs. . . .We just didn't think about things like that" (42). Because Morrison's white, middle-class, small-town background, secure family life, and academic achievements stand in contradistinction to cultural expectations of "the drug addict," they allow Morrison to cultivate a severe drug addiction without being a suspected and stigmatized addict.

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[18] Morrison recalls protesting the Vietnam War, but she confesses, "I was never that serious about politics – the social protest just came with the drugs" (42).

Her adherence to normative or stereotypical assumptions about the relationship between class and drug addiction likewise prevents Morrison herself from imagining her drug use as problematic. Analyzing the introductory excerpted diary entry that refers to her injecting methamphetamine, Morrison writes,

> Clearly, at the time I wrote this account, I had no idea whatsoever that I was an addict. Despite an extremely troubled history with drugs, despite my training as a physician, the fact that I was addicted eluded me completely. How could I be a junkie? I had been an exceptional student and was now an award-winning medical resident. I lived in a nice house, had a respectable husband and a reasonably happy family life. I had my shit together. Moreover, I was a star in my particular stratosphere. (6-7)

The relation that Morrison constructs here between her class identity, especially embodied by her status as a medical professional, and her addiction presumes the inadequacy of socioeconomic explanations of addiction. Unlike the majority of American female (illicit) drug addicts, Morrison cannot cite poverty, an abusive family environment, childhood trauma, or lack of access to education as the causes of stress that lead to addictive drug use (McCaul and Svikis 432). Without this socioeconomic narrative of causation or a (potentially related) trauma narrative,[19] Morrison turns to a narrative of causation that conceptualizes addiction as a result of inherited, uncontrollable, individual physiological conditions and conceptualizes the addict as a blameless and socially acceptable victim of these conditions.

While Morrison is quick to establish her class and familial background as "terribly normal" (17), she is just as quick to identify characteristics of her gender as unusual. In the opening pages, she describes herself as "something of a tomboy, . . . tough and athletic" (10). "I always played to win," writes Morrison, "and win I did. . . . I was also somewhat unruly and rebellious" (10). A little later on, she recalls, "I always felt my relationships with women were a little more problematic and confusing than my relationships with men. . . . Also, I learned early on that I could manipulate men" (15-16). As characteristics of her childhood gender identity alone, these traits are not particularly remarkable. They resonate later, however, during Morrison's stay at Ridgeview when she is derided for being competitive, manipulative, tough, and outspoken. Part of her predilection for addiction, and, indeed, pathologized as such in the psychologist's evaluation of Morrison's

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[19] Morrison may have not experienced any direct childhood trauma, such as sexual or physical abuse, but she presents a psychological portrait of herself that in some significant ways resembles that of a traumatized person. This kind of self-portraiture is, in fact, common to many women whose stories of addiction I have read, and I discuss this phenomenon in the next chapter. Here it suffices to note that from early on in the book, Morrison describes overwhelming emotional and psychological pain, which she learns to alleviate with drugs. She writes, "At this point, [junior year in high school], I had suffered no terrible or significant traumas, but I still felt a ragged, intense pain. I believed I was the only one in the world who felt confusion and pain, and certainly the only one who experienced it so intensely" (27).

"masculine identification" (171), these gendered characteristics must be neutralized in order for her to recover.

With these violations of female gender roles as provocation, a male counselor named Donnie informs Morrison of her proper position and social offense: "[Y]ou're powerless, and you have no control. . . .You're afraid of women. . . .You need to learn to be with the women. . . I'm going to clean out your mouth, make a lady of you" (197). Donnie's remarks are, of course, frighteningly reminiscent of the moral prescription that O.W. receives almost sixty years earlier – "Behave like a lady," Dr. Grover tells O.W.. But what is perhaps more disturbing about this moral prescription in Morrison's story is that she comes to interpret her so-called "masculine identification," her supposed failure to be a "woman," as part of the pathology that produced her addiction. She does not consider how her "masculine identification" may have determined her success in the male-dominated profession of medicine. When Morrison recollects "always [being] one of the boys" (11) at the beginning of the book, it is with a sense of diagnosis. Like other early behaviours and emotions, violations of gender norms signal an underlying illness, a sign of the addiction-disease to come.

After the confrontation with Donnie, Morrison's recovery is largely focused on "getting with the women" (204). In a seemingly mechanical tone, Morrison reiterates this lesson of recovery: "I had to learn to relate to women better before I could maintain a healthy relationship with a man. . . . I would learn what I needed – how to trust people, for example – only through intimate relationships with women" (203-4). Drawing on stereotypes of women as emotional and moody, Donnie adds to his analysis of Morrison's "problems with women": "For whatever reason, [women] have faster mood swings and greater shame and guilt than men do . . . I suspect these were some of the reasons relationships with women were scary to Martha" (205). Recovery discourses, argues Melissa Friedling, among other feminist critics, act in the service of heteronormativity (5). Friedling writes,

> Recovery in [clinical, popular, philosophical, political] discourses describes a typically logocentric discursive practice that is structured by binary logic and grounded in truth claims and norms . . .[T]he rhetoric of recovery presupposes that a truth exists and might be found by peeling away layers that conceal an authentic core. Rhetorics of recovery contain in condensed form many of the prescriptive pairings basic to modern cultural "order": culture/nature, mind/body, self/other, real/representation, public/private, health/illness, voluntarity/addiction. A recovery rhetoric seeks to uncover the second term in order to cover over and demonstrate the centrality and dominance of the first, ascendant term – the norm. Recovery, then, requires the affirmation of an imagined 'other' in order to assert the truth of the norm. (61)

Framed in the above confrontation as the necessity of recovering proper femininity, Morrison's addiction recovery exemplifies Friedling's articulation of recovery discourse as working to affirm and reassert the norm.

Indeed, *White Rabbit* ends with Morrison marrying Dr. Talbott's son and returning to work, this time as an addiction treatment specialist. Morrison's successful recovery, then, is signaled by heteronormative romance and the attainment of white, middle-class notions of productivity and expertise, narratives that both shape and are facilitated by the disease concept of addiction. As a white, middle-class woman seeking treatment in the early 1980s, Morrison falls under the newly sheltering effects of the disease model, even as she initially rejects the notion of addiction-as-disease. Encouraged to hold the disease responsible for her addiction, she is able to construct her social identity as a "sick" person, and, as such, recovery reassures the renewal and maintenance of her class privilege and heteronormativity.

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Although I have made some definitive remarks about the utility of the disease concept, as Morrison's story illustrates, the meaning of "disease" in addiction and recovery discourses is not straightforward; nor are the implications of the disease concept in the lives of addicts. In addition to the kind of social and cultural shelter Morrison experiences under the disease concept, she also experiences liberation from the painful and puzzling thoughts and emotions that she associates with her addiction. As violators of powerful constructs of their roles as nurturers and guardians of morality, white, middle-class, female addicts, including Morrison, express tremendous guilt and shame over their addictions, and I do not mean to underestimate the value of relieving these often debilitating emotions. I am not convinced, however, that reconceptualizing oneself as "sick" with a "disease" over which one has no control and no power is the best means to assuage these emotions; but these are the terms under which white, middle-class female addicts earn cultural redemption.

Morrison's negotiation of the disease concept crystallizes many of the issues that circulate in mainstream discourses of addiction, which also recur throughout this project: social versus individual responsibility, the pathologization and
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medicalization of behaviour, the relationship between femininity and illness, and the heteronormative imperative of recovery, to name a few. In its late-twentieth and early-twenty-first-century ubiquity, the disease concept, its related issues, and its historically persistent terms of debate suffuse white, middle-class women's stories of addiction even when the authors do not explicitly engage with the notion of addiction-as-disease. Following Craig Reinarman, who, in "Addiction as Accomplishment: The Discursive Construction of Disease," argues that the contemporary ubiquity of the disease concept of addiction is a "species of social accomplishment" (308), this chapter has shown that "the disease concept was invented under historically and culturally specific conditions, promulgated by particular actors and institutions, and internalized and reproduced by means of certain discursive practices" (Reinarman 308). The "social accomplishment" of the disease concept's current ubiquity is, of course, that its history is invisible. While this ahistoricity is often manifest in women's uncritical acceptance of the disease concept – it simply "makes sense," to quote NA – the women nonetheless negotiate the historical complexities of identifying, and of being identified as having a "disease" that has variously configured "the addict" as contagious, psychologically deviant, and culpable, on the one hand, and blameless but inherently and constantly vulnerable, on the other.

Feminist critics such as Janice Haaken have noted a similarly contradictory but reductionist tendency in the trauma model, which became a prominent narrative framework for many women's life stories during the "memoir boom" of the 1990s (Gilmore 128),[20] and which Susan Gordon Lydon uses in her memoir, *Take the Long Way Home*, to frame her addiction narrative. Like the disease model, the trauma model subsumes a broad range of experiences and symptoms under a single, medicalized rubric, and provides a unifying basis for group identity (Haaken, "Recovery of Memory" 1084). The trauma model, critics claim, limits women to the role of victim (Lamb 111); like addicts who suffer from the life-long "disease" of addiction and must always be on guard against relapse, traumatized women are not only seen as eternally suffering and "continually reacting to their abuse," but also as "not responsible for their reactions to the abuse" (Lamb 116). Thus, like the disease concept of drug addiction, the dominant paradigm of psychic trauma is based on "absolute captivity" (Haaken, "Recovery of Memory" 1090). Trauma and the disease concept constitute a similar lens of pathology that therefore raises questions about individual and social responsibility. What happens, then, when women use the concept of psychological trauma to explain their drug addictions? What happens when the contradictory (but limiting) subjectivities of addiction discourses intertwine with those produced in the discourses of trauma? I take up these questions in the next chapter as I analyze Lydon's use of trauma as the narrative framework of her story of addiction.[21]

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[20] In her 2002 book, *Repossessing the World: Reading Memoirs by Contemporary Women*, Helen Buss suggests that many late twentieth-century memoirs written by women originate in public and private instances of trauma (xxv). Exploring the "coincidence of trauma and self-representation" in her article, "Limit-Cases: Trauma, Self-Representation, and the Jurisdictions of Identity," Leigh Gilmore also notes that "the memoir boom's defining subject has been trauma." Refer also to Janet Mason Ellerby's *Intimate Reading: The Contemporary Women's Memoir* for a discussion of trauma's centrality to contemporary autobiography and self-representation.

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[21] Incidentally, Lydon and Morrison are also connected by self-help's fundamental propagandistic function; on her way to rehab, Lydon reads "a personal account of addiction and recovery written by Martha Morrison" in the back pages of a women's magazine (Lydon 221). "Lydon recalls the last lines of Morrison's article and effect they had on her: "'There is hope,' she said at the end of her story. 'We do recover.' It made an impression on me, I suppose because the timing could not have been more dramatically propitious if it had been scripted in Hollywood" (221). Morrison's prefatory wish that she might offer her "hope" to other addicts is thus fulfilled.

Chapter Three

"The soil in which my addiction could take root and grow": Trauma and Susan Gordon Lydon's *Take the Long Way Home*

Of all the women whose stories of addiction I read in this project, Susan Gordon Lydon is the only self-identified feminist. In her 1993 memoir, *Take the Long Way Home: Memoirs of a Survivor,* Lydon writes from "the vantage point of a generation of second-wave feminist pioneers" (Friedling 65). She recounts "the early days of the women's movement" (Lydon 83) and "celebrates the importance of her generation of feminist consciousness-raising" (Friedling 65). Lydon, in fact, was actively involved with one of the first consciousness-raising groups at Berkeley in 1967 (Lydon 82). She writes, "So as not to be mistaken for NOW [National Organization for Women], considered far too moderate for this radical group, we called ourselves 'women's liberation.' . . . We talked about our personal lives and found numerous common concerns, articulating a concept that would become a trademark of the women's movement: that the personal is political" (82).

This second-wave feminist mantra informs Lydon's memoir and, more specifically, her conceptualization and narrativization of her drug addiction. Lydon effectively links the personal and psychological dimensions of her experiences of drug use and addiction to the "institutionalized nature of sexual oppression" (Felski 115), and she contextualizes her drug use with reference to the sociopolitical and material conditions of the day, particularly in the first half of the book. Her memoir also represents and illustrates what are arguably the most significant legacies of second-wave feminism's consciousness-raising and its propagation of the notion that *the personal is political*: the feminist reconceptualization of trauma to include women's everyday experiences of interpersonal violence and the emergence of survivor discourse.

Take the Long Way Home is organized chronologically and divided into three parts: "Book One: The Making of an Addict," "Book Two: Abandon Hope, All You Who Enter Here," and "Book Three: Getting Free." As these titles suggest, Lydon maps a narrative of escalating drug use, which leads to addiction and a life of degradation before she eventually "gets free" in recovery. Nearing the conventionally epiphanic "rock bottom," Lydon lives in squalor and supports her heroin and crack habit with drug dealing and prostitution while incidents of interpersonal violence intensify. It is not, however, Lydon's experiences as a drug addict that earn her the "survivor" label that she attaches to herself in the book's subtitle. Rather, what she "survives" is a complex history of psychological trauma that entirely precedes her drug use. Evidencing a keen familiarity with and understanding of therapeutic discourses, especially feminist psychotherapy, Lydon constructs a narrative of trauma to conceptualize and explain her drug addiction. In other words, Lydon's history of trauma, which includes incest and childhood experiences of physical and emotional abuse, as well as transgenerational trauma attached to her Jewish ethnicity and her gender identity, provides the primary lens through which she interprets her drug addiction.

Lydon is certainly not the first to make a direct link between her various experiences of trauma and her drug use. Indeed, many women's stories of drug addiction begin with the recollection of childhood traumas, such as sexual and physical abuse and the death of a parent.[1] Moreover, as women's repeated descriptions of drugs' emotionally anaesthetizing effects demonstrate, women often see their drug use as a response to the overwhelming emotional and psychic pain associated with traumatic events or circumstances.

Institutionally, researchers and clinicians within psychiatry and psychology have long noted a "high frequency of trauma history in addicted populations" (Zweben, Clark and Smith 327). In fact, the relation between what the American Psychiatric Association calls "substance use disorder" (SUD) and post-traumatic stress disorder (PTSD) constitutes a kind of sub-field within psychiatry's study of addiction. In the language of psychiatry, there is a "high comorbidity" – a concurrence or co-existence – of the two conditions (Brown, Recupero and Stout 251). "Dual diagnosis" of PTSD and drug addiction or SUD is common (Dayton xxiii).[2] A 2004 study published in *Addictive Behaviors* found that almost 95% of those who were in in-patient treatment for substance use disorder reported a history of trauma (Read, Brown and Kahler). Psychiatry generally understands substance abuse as one of the many sequelae of traumatic experiences (Zweben, Clark and Smith 331). Child abuse in particular is regarded as a key etiological factor of substance dependence (Sullivan and Evans 369; Root, "Treatment Failures" 542; Zweben, Clark and Smith 331; Dayton xxiii; Carnes 5).

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[1] Even O.W.'s *No Bed of Roses*, which predates the mainstream emergence of the concept of psychological trauma, opens with what we today recognize as a traumatic event and its sequelae: O.W. describes herself as a "restless and unhappy" (10) child; she speculates, "Perhaps my mother's untimely death left this gap in my life" (10).

[2] In their article, "PTSD Substance Abuse Comorbidity and Treatment Utilization," Pamela Brown, Patricia Recupero, and Robert Stout argue that the "the dual diagnosis caseload has become one of the most pressing service delivery problems facing substance abuse treatment systems" (251). For discussion of the politics of dual diagnosis in the United States, see Chapter 4, "Double Trouble: The War Zone of Dual Diagnosis" in Lonny Shavelson's *Hooked: Five Addicts Challenge Our Misguided Drug Rehab System.* For a self-help explanation of dual diagnosis, see clinical psychologist Tian Dayton's *Trauma and Addiction: Ending the Cycle of Pain Through Emotional Literacy*, especially Chapter 1, "The Connection Between Trauma and Addiction."

Furthermore, psychiatry and psychology widely recognize that trauma histories are more prevalent among addicted women than among their male counterparts (Cottler et al. 644; Brown, Recupero and Stout 251). As Maria Root notes in her article, "Treatment Failures: The Role of Sexual Victimization in Women's Addictive Behavior," studies of women in treatment for substance abuse disorders consistently reveal that "histories of childhood sexual abuse and rape are common" (542). Psychiatry and other therapeutic disciplines conceptualize women's experiences of childhood sexual abuse as an important etiological factor of their drug addiction (Zweben, Clark and Smith 331).

These disciplines, however, neglect to locate this etiology within a broader sociopolitical context. Although psychiatry in particular recognizes a close relation between traumatic experiences and drug addiction, it treats drug dependence as a distinct and individual pathology, a "disorder" whose cure is entirely separate from systemic relations and the sociopolitical circumstances of its trauma etiology. The medically accepted correlation between individual traumatic experiences and drug addiction, in other words, rarely resonates within a broader cultural and political context.

Feminism intervenes here: "feminist theory always considers the interplay between sociopolitical facts and phenomenological experience," asserts Root in "Reconstructing the Impact of Trauma on Personality" (236). "Consistent with feminism's initial proclamation that the 'personal is political'" (238), feminist conceptualizations of trauma move "the analysis of the problem beyond an individual perspective to a larger sociopolitical, systemic framework" (Root, "Reconstructing" 238). Another significant contribution of a feminist perspective to the understanding of trauma is its efforts to "depathologize normal responses to horrible experiences" (Root, "Reconstructing" 237; see also Nicki 82; Brown 125). As Root argues, "many of the behaviors we see after trauma are manifestations of specialized coping behaviors for survival" ("Reconstructing" 237) rather than signs of instability, impaired emotional functioning, or, most generally, pathology (Root, "Reconstructing" 248). Within this feminist conceptualization of trauma, then, women's drug addiction is not pathological; it is a "normal," adaptive response to traumatic events and various facets of oppression.

This chapter is concerned with the effectiveness of trauma as a feminist framework for representing and understanding women's drug addiction. As such, it aims to address one of the main methodological questions of this project: What role does trauma theory have in reading women's stories of drug addiction? More specifically, I ask, does Lydon's use of trauma disrupt dominant medical concepts of drug addiction as pathological? Or does the discourse of trauma, even within feminist practices such as Lydon's, reproduce the logic of the conventional medicalized model of not only addiction, but also psychopathology more generally (Marecek 165)? And within the convergence of the discourses of trauma and addiction, what subject position(s) does Lydon as an addicted woman occupy? Given that both drug addiction and PTSD are popularly understood as enduring, often life-long conditions that have compelling biological explanations and are said to dictate the sufferer's behaviour and definitively shape her identity, are addicted women helpless and long-suffering victims of both abuse and drugs? How does Lydon negotiate this configuration of the female addict as victim? What agency can she find here? And how does femininity play out in the intertwined discourses of trauma and addiction, in narratives that, like Lydon's, directly connect women's experiences of childhood abuse with their drug addiction?

Although Lydon evidences an intimate familiarity with and thorough understanding of therapeutic discourses, she does not explicitly seek to engage with expert discourses of psychological trauma or feminist therapy. Nonetheless, she shares not only a political commitment, but also a social and historical context with many feminist theorists of trauma. Published in 1993, Lydon's memoir is contemporaneous with an interdisciplinary feminist body of literature that emerged from and built on the political momentum and theoretical insights of the 1970s women's movement and its public exposure of women's everyday, private experiences of trauma. This chapter sketches three key feminist contributions to trauma theory in the late twentieth century: the expansion of the conventional concept of trauma to include women's everyday and ongoing experiences; out of this expansion, the development of the concept of "insidious trauma"; and the depathologization of adaptive, "normal responses" to trauma. Governing each of these contributions is an overarching emphasis on trauma as a systemic rather than individual problem.

Weaving excerpts from Lydon's memoir into my theoretical summaries, I consider how Lydon uses, contributes to, or otherwise engages with each of these feminist interventions as she constructs a trauma narrative as the interpretative framework for her addiction. Lydon establishes trauma as a framework in her first chapter, "A Lost World – 1943," where she outlines what she sees as the main psychological factors of her addiction: her problematic Jewish identity, experiences of incest at the hands of her maternal grandfather, a physically and emotionally abusive relationship with her father, and a discomfort with the femininity that she learns from her mother. Drawing on the feminist perspectives and revisions of trauma, Lydon represents each of these factors as a kind of trauma and explains their effects on her self-perception and worldview, which she in turn links to her addiction.

I begin, however, by locating the feminist contributions to trauma theory within the historical context of the 1970s. I also delineate Lydon's feminist politics, which provide a context for interpreting her conceptualization of trauma and her intertwined narrative of trauma and addiction.

The 1970s: Raising Consciousness and Diagnosis

Scientific, institutional and broader cultural attention to trauma, Judith Herman shows, has only been achieved when accompanied by a political or social movement (9, 32; Cvetkovich 31). In the late twentieth century, the feminist movement in Western Europe and North America brought into public consciousness the psychological trauma of sexual and domestic violence (Herman 9).

Feminist clinicians and theorists "followed in the wake of the Vietnam veterans movement and its refusal to be silenced over the sustained, debilitating effects of war" (Haaken, "Recovery of Memory" 1078). Antiwar veterans organized "rap groups," intimate meetings where Vietnam veterans, sometimes in the presence of sympathetic psychiatrists, retold their traumatic experiences of war (Herman 26-7). A kind of precursor to feminist consciousness-raising groups, "rap groups" not only provided solace to individual veterans, but also raised public awareness about "the lasting psychological injuries of combat" (Herman 27). By the end of the 1970s, "the political pressure from veterans' organizations resulted in a legal mandate for a psychological treatment program" (Herman 27). In 1980, psychic trauma gained official recognition as a diagnostic category in psychological medicine with the publication of the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*), which named "posttraumatic stress disorder" as a new category (Freedman; Herman 28). As Herman observes, "The moral legitimacy of the antiwar movement and the national experience of defeat in a discredited war had made it possible to recognize psychological trauma as a lasting and inevitable effect of war" (27). For most of the twentieth century, then, the study of combat veterans shaped the body of knowledge about traumatic disorders (Herman 28). Building on the insights of Vietnam War activists and the legitimacy their ideas attained, feminists began "to notice that survivors of rape, domestic battery, and child abuse shared essentially the same symptoms as those seen in war veterans" (Freedman). As Herman states, "Not until the women's liberation movement of the 1970s was it recognized that the most common post-traumatic disorders are not those of men in war but of women in civilian life" (28).

A hallmark of second-wave feminism, consciousness-raising groups sought to break the silence that surrounded the conditions of women's lives and expose violence hidden in the sphere of the personal. Interestingly, Lydon describes the formation of the consciousness-raising group at Berkeley as a response to women's "dissatisfaction with the subordinate roles they played to men in the student antiwar movement" (82). The group's focus quickly shifts, however, to women's personal lives (Lydon 82). Lydon writes, "This was the era before intimate disclosures in self-help groups became the norm; we were some of the original support groups. Before our group we had been isolated within our own homes; there were private areas of our lives we simply did not share" (83). Lydon's remarks not only allude to what Elayne Rapping calls "the feminist paradigm . . . at work in the recovery [or self-help] movement" (55); they also convey the power of the discourse of separate spheres and, within it, the devaluation of the private, feminized space of domesticity. Lydon goes on to describe the "explosive energy" (83) of the group: "It's hard now to reconstruct how powerful those first moments of self-revelation were. . . .We were taking steps to free ourselves" (83). For the first time, women spoke freely about their personal lives, including experiences of sexual assault and abuse, and they articulated the relevance of these experiences and interactions to public and political life.

As a method of consciousness-raising, self-revelation or self-disclosure was intended to effect social rather than individual change, although, as Herman notes, the methods of consciousness-raising were analogous to those of psychotherapy (29). With Lydon's reference to the self-help movement and its foundational practice of self-disclosure, Herman's acknowledgement of this parallel between consciousness-raising and psychotherapy raises a characteristic tension or common criticism of second-wave feminism – its therapeutic function. In her book, *Recovering Women: Feminisms and the Representation of Addiction*, Melissa Friedling argues that:

> Second-wave consciousness-raising, though legitimizing personal experience as politically significant, assigned to feminism a therapeutic function as the cure for the disease of patriarchal psychic colonization. . . . The consciousness-raising strategies of feminists who responded to real conditions of existence offer a *cure* in a structural healing based on the illumination of commonality in the shared source of their oppression and compels women to look inside themselves for the source of their oppression. (64)

Lydon's own aspirations for the group reflect the problematic conceptualization of feminism as a therapeutic practice. She writes,

> Where others wanted to focus on how to change things in the movement, I wanted our analysis to include broader issues, like equality in the workplace, and to delve more deeply into questions of identity. Traditional stereotypes of women and femininity had failed to provide me with a model I could live by. I argued that we should search for the essence of what it meant to be a woman; to explore what, apart from the obvious biological differences, had been provided us by nature rather than social conditioning. (83-4)

Lydon's assertion that "traditional stereotypes of women and femininity had failed to provide [her] with a model [to] live by" (83) contextualizes her individual(ist) and seemingly essentialist pursuit of "woman" as a therapeutic quest; this comment is an allusion to what Lydon discusses throughout her memoir as the trauma of sexism and its constructs of femininity. In particular, Lydon shows how what she learned as a child about "what it means to be a woman" contributed to a negative, problematic sense of self. This passage suggests that she sees feminism, at least in part, as an individual therapeutic practice, as a means of "repairing" or making up for the failure of "traditional stereotypes of women and femininity" (Lydon 83) in her own life.

Lydon adds that she hoped that this exploration of the "natural" "essence" of "woman" would encourage the group to begin to "define [them]selves and [their] roles in society from a more authentic core" (84). The notion of an "authentic core" complements the concept of a unified category of "woman," which Lydon proposes and which second-wave feminism has been charged with promoting (Friedling 65). By comparing consciousness-raising to popular self-help or Twelve-Step recovery programs, Friedling demonstrates how consciousness-raising feminism's construction of the totality of "woman" is a constituent of its therapeutic function. Friedling borrows from Eve Sedgwick's analysis of the Twelve-Step movement in "Epidemics of the Will" to explain this relation:

> Like popular self-help or twelve-step recovery programs, consciousness-raising requires submission to the insistence of absolutes in the 'subscription to an anti-existential rhetoric of unchangeable identities' . . . The 'unchangeable identities' in the recovery rhetoric of consciousness-raising feminist theorists are derived from a valorization of maternal essence. This theory-producing feminist framework constructed a unified category of 'woman.' (64-5)

Lydon's articulation of her consciousness-raising feminist politics is important, therefore, because it represents a paradigm of subjectivity upon which she also draws in conceptualizing herself as an addict and as a woman who has experienced trauma. For Lydon, each of these discourses – feminism, addiction and trauma – provides a similarly deterministic identificatory structure insofar as they each suppose an original, formative and inevitable "injury" or "loss" that not only necessitates a process of recovery, but also remains central to a "recovered" identity. This is not to say, however, that feminist consciousness-raising compels Lydon to look exclusively inside herself for the origins of her emotional discomfort, psychological pain, and oppression.

Lydon recognizes consciousness-raising as a strategy by which second-wave feminists cultivated an understanding of sexual assault as a condition of "the phallocentric nature of Western institutional, cultural, and political power structures" (Friedling 64). Overall, as Herman suggests, the feminist understanding of sexual assault fostered within and by consciousness-raising groups "empowered victims to breach the barriers of privacy, to support one another, and to take collective action" (Herman 29). Lydon's representation of the Berkeley group also illustrates these social and cultural (as opposed to individual) processes and effects. She recalls, "As each woman . . . began to bare her secrets, pouring out her sorrows and rage and frustration, other women in the room experienced what Ms. magazine later called 'the click of recognition,' that empathetic feeling of, 'Yes, my life is like that too.' A collective sense of outrage grew as we coalesced into a strong group and began to develop an ideology and debate possible courses of action" (83).

One such "course of action" was the first public speakout on rape, staged by the New York Radical Feminists in 1971 (Herman 29). By the mid-1970s, the National Organization for Women (NOW) had initiated rape reform legislation, and the women's movement had "generated an explosion of research on the previously ignored subject of sexual assault" (Herman 30). The feminist movement not only documented pervasive sexual violence for the first time; it also offered "a new language for understanding the impact of sexual assault" (Herman 30). Herman provides a succinct summary of the resultant discursive reconstruction of rape as psychic trauma: "Entering the public discussion for the first time, women found it necessary to establish the obvious: that rape is an atrocity. Feminists redefined rape as a crime of violence rather than a sexual act. . . . Feminists also redefined rape as a method of political control, enforcing the subordination of women through terror" (30-1). The women's movement also "initiated a new social response to victims" (Herman 31); women established rape crisis centers that offered practical, legal, and emotional support to rape victims outside the conventional medical framework (Herman 31). Rape, therefore, was "the feminist movement's initial paradigm for violence against women in the sphere of personal life" (Herman 31) and, as such, it also constituted the paradigm through which the concept of psychic trauma became part of feminist discourse. The recognition of domestic violence and other forms of private coercion as forms of trauma in women's everyday lives grew out of this initial focus on rape (Herman 31).

The 1970s, then, was a period of mobilization around sexual assault, domestic battery and incest (Haaken, "Recovery of Memory" 1073). The creation of the diagnostic category of post-traumatic stress disorder (PTSD) in 1980 "validated" women's abuse experiences by legitimating the notion that abuse led to psychological distress and damage. Other post-traumatic syndromes had been proposed prior to the creation of the PTSD diagnosis; "rape trauma syndrome" (Burgess and Holmstrom) and "battered women's syndrome" (Walker), for instance, "highlighted the effects of those assaults on the victims' sense of safety, trust and self-worth, and on their continued sense of terror" (van der Kolk, "Assessment" 4). As Bessel van der Kolk explains, however, "The *DSM-III* definition of PTSD, guided by [American psychiatrist Abram] Kardiner's description of the 'traumatic neuroses of war' (1941) and [psychiatrist Mardi] Horowitz's biphasic stress response syndrome (1978)[,] highlighted *the physiological alterations* that follow traumatization, and the co-existing traumatic intrusions and emotional numbing and avoidance" (emphasis mine; "Assessment" 4).[3] Indeed, psychological trauma gained legitimacy as theorists and clinicians emphasized its biological basis and physiological consequences. In their online article, "Conflict Between Current Knowledge about Posttraumatic Stress Disorder and Its Original Conceptual Basis," Rachel Yehuda and Alexander McFarlane assert that "the field of biological studies of stress, which essentially justified a normal continuum of responses to adversity" was "a major intellectual cornerstone for early conceptions of PTSD." In particular, they explain, "[Hans] Selye's findings that any adversity could provoke a biological stress response provided a scientific validity of the conception of PTSD that was derived from scientific observations and *not from the need to advocate on behalf of*

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[3] Van der Kolk is referring to Kardiner's influential 1941 book, *The Traumatic Neuroses of War*. For a historical account of how Kardiner's work shaped the concept of PTSD, see Herman's "A Forgotten History," the first chapter in *Trauma and Recovery*.

victims" (emphasis mine; Yehuda and McFarlane). While previously proposed post-traumatic syndromes like "rape trauma syndrome" and "battered women's syndrome" acknowledged women's psychological distress as a consequence of such abuses, the PTSD diagnosis offered a broader and more culturally convincing "validation of the [physiological] aftereffects of [these abuses] and a way of understanding, explaining, and classifying [and I would add, perhaps most importantly, treating] the variety of post-traumatic symptoms" that those working to oppose violence against women were witnessing (Freedman).

This brief history illustrates a key tension around how experiences of trauma and expressions or manifestations of psychic pain, including drug addiction, are culturally validated; and it is a tension that Lydon also faces as she discloses and represents her experiences. As explanations of abusive behaviour and its consequences, medicine, with its biological "evidence," carries more cultural weight than social movements like feminism, with its critique of social structures and institutions. While Lydon links her experiences of abuse and subsequent suffering to sociopolitical conditions and systemic oppression, she also invokes medical conceptualizations of trauma, which lend a greater degree of cultural audibility and authority to her voice. Even Lydon's articulation of her feminist politics as a kind of therapeutic practice begins to evoke this tension between medical (psychiatric) and political conceptualizations of female maladies.

Expanding the Conventional Notion of Trauma

The feminist understanding of women's private, personal and everyday experiences of violence as traumatic nonetheless challenged the concept of trauma as a discrete, public event. As Ann Cvetkovich suggests, "one of the most useful contributions of a feminist approach to trauma . . . is the focus on trauma as everyday that unravels definitions of the term. . . .More so than distinctions between private and public trauma, those between trauma as everyday and ongoing and trauma as a discrete event may be the most profound consequence of a gendered approach" (32).

In her article, "Not Outside the Range: One Feminist Perspective on Psychic Trauma" (1991, 1995),[4] feminist therapist Laura S. Brown recounts her experiences in a courtroom where a defense attorney cites the then-current *DSM* definition of a traumatic event as "an event that is outside the range of human experience" (American Psychiatric Assocation *DSM-III-R* qtd. in Brown 100) to discredit Brown's diagnosis of a female patient who experienced repetitive and continuous incest:

> How, asked this attorney, who represented the perpetrator, could my patient possibly have PTSD? After all, wasn't incest relatively common? I had myself testified only minutes earlier that as many as a third of all girls are sexually abused prior to the age of sixteen. Incest wasn't unusual, wasn't 'outside the range of human experience.' How could it be called a trauma? . . . How could such an event which happens often to women, so often in the life of one woman, be outside the range of human experience? (101)

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[4] "Not Outside the Range" was first published in *American Imago* in 1991 (two years before the publication of Lydon's memoir) and republished in Cathy Caruth's 1995 collection, *Trauma: Explorations in Memory*. I cite the 1995 version of the essay, unless otherwise specified.

Drawing on Diana Russell's 1986 book, *The Secret Trauma: Incest in the Lives of Girls and Women*, Brown reiterates that for girls and women, traumatic experiences such as incest and rape are not unusual statistically: "They are well within 'the range of human experience.' . . . They are experiences to which women accommodate; potentials for which women make room in their lives and their psyches" (101). And they are experiences that occur in secret, unlike "agreed-upon traumata" such as war and natural disasters (Brown 102). Revealing how "the classic definitions of appropriate etiologies for psychic trauma" serve "the dominant class [–] white, young, able-bodied, educated, middle-class, Christian men" (Brown, 1991 121) – Brown calls for a feminist perspective on trauma that looks "beyond the public and male experiences of trauma to the private, secret experiences that women encounter in the interpersonal realm and at the hands of those we love and depend on" (102). Importantly, she adds, "Feminist analysis also asks us to understand how the constant presence and threat of trauma in the lives of girls and women of all colors, men of color in the U.S., lesbian and gay people, people in poverty and people with disabilities has shaped our society, a continuing background noise rather than an unusual event" (102-3). Brown, and feminism more broadly, thus challenged the conventional definition of trauma as a direct assault and a distinct and/or unusual event. The American Psychiatric Association responded to feminist analyses of trauma by revising the definition of a traumatic stressor in the 1994 edition of the *DSM*: "Criterion A for post-traumatic stress disorder . . . no longer require[s] that an event be infrequent, unusual, or outside of a mythical human norm of experience" (Brown 111).[5]

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[5] Brown criticizes the American Psychiatric Association's revision for its failure "to

Incest: Lydon's Earliest Traumatic Memories

Lydon's memoir and her claim to the "survivor" label reflect this relatively recent medical and cultural recognition of sexual abuse, emotional abuse, and other forms of interpersonal violence as "valid" traumatic experiences (Root, "Reconstructing" 239), a recognition effected, of course, by consciousness-raising and feminist calls for the expansion of the conventional notion of trauma. Recalling memories of her early childhood, Lydon reveals that she and her sister Lorraine "now believe that [their maternal grandfather] sexually molested [them] as children" (13). Lydon admits that she is uncertain about what happened, but she describes the experience as unmistakably traumatic and formative:

> I couldn't swear to it in a court of law, because I was so young when it happened that the memories are neither visual nor verbal but sensory and

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provide us with a diagnosis to describe the effects of exposure to repetitive interpersonal violence and victimization" (111). *In Trauma and Recovery*, Herman also argues that "the syndrome that follows upon prolonged, repeated trauma needs its own name" (119). She proposes to call it "complex post-traumatic stress disorder" (119). See Chapter 6, "A New Diagnosis" in *Trauma and Recovery* for a discussion of the need for a new concept. Herman also provides a proposed diagnostic criteria for Complex PTSD on page 121. The APA has recognized that "PTSD captures only a limited aspect of post-traumatic psychopathology" (Luxenberg, Spinazzola, and van der Kolk 374) and has subsequently developed the designation, Disorders of Extreme Stress Not Otherwise Specified (DESNOS), "which has a symptom constellation delineated in the DSM-IV under 'associated features of PTSD'" (Luxenberg, Spinazzola, and van der Kolk 374). As Luxenberg, Spinazzola and van der Kolk explain in "Complex Trauma and Disorders of Extreme Stress (DESNOS) Diagnosis, Part One: Assessment," "Though DESNOS is not currently a distinct diagnosis in the DSM-IV, its symptom constellation has been identified in numerous research studies and is currently being researched and considered for inclusion, as a free-standing diagnosis, in the DSM" (374). For a thorough account of the clinical symptomatology of DESNOS, its differences from PTSD, and how psychiatrists assess patients for it, refer to the aforementioned article.

> vague. I am still piecing them together, bit by bit, slowly, because each degree of memory brings an agony of pain. Whatever happened was so traumatic that I blocked out any knowledge of it for over forty years. Incest. Hard to believe. . . . But the evidence that it did happen is too overpowering: the particular corrosion of spirit that incest brings too present in me, the healing that's gone on too dramatic and telling to be repudiated. (13-14)

Lydon's admission that she does not have clear, "narrative" memories of her experiences reflects a shift in the cultural discourse of trauma to accommodate what Linda Alcoff and Laura Gray-Rosendale call "survivor speech" (203). While psychiatry built the concept of trauma on the notion that traumatic experience is not subject to "the usual 'declarative' or 'explicit' or 'narrative' mechanisms of memory and recall" (Leys 247), and instead is "organized on a somatosensory or iconic level [as] somatic sensations, behavioral reenactments, nightmares, and flashbacks" (van der Kolk and van der Hart 172), society has traditionally understood such behaviours and the absence of lucid memories as either symptoms of hysteria and other psychological disorders or evidence of women's mendacious tendencies. As Alcoff and Gray-Rosendale write, "at various times and different locations [survivor speech] has been absolutely prohibited, categorized as mad or untrue, or rendered inconceivable" (203). The feminist movement helped reduce the effectiveness of such silencing techniques by creating forums where women could tell their stories of abuse (Alcoff and Gray-Rosendale 205-6).

Life-writing might be thought of as one such forum, although its inextricable relation to the publishing industry raises questions about the extent to which survivor speech is subsumed, or as Alcoff and Gray-Rosendale suggest, "recuperated" (206) by dominant discourses. On the one hand, Lydon's account of incest is potentially disruptive or "transgressive" (Alcoff and Gray-Rosendale 204); in second-wave feminist terms, it is "speaking out," an act that not only challenges conventional speaking arrangements in which women have been denied authority and the space to be heard (Alcoff and Gray-Rosendale 204), but also exposes and challenges patriarchal oppression (Alcoff and Gray-Rosendale 206). On the other hand, Lydon's "survivor speech" is part of her narrative of addiction, and dominant discourses of addiction usually overlook or minimize social structures and "underlying systems of dominance" (Alcoff and Gray-Rosendale 206). In psychiatry, the assured recognition of women's experiences of incest and other forms of child abuse as key etiological factors of addiction can be thought of as a kind of accommodation of survivor discourse; but such accommodation does not necessarily translate into a critique of oppressive social structures.

Lydon continues to recount what she has "been able to reconstruct" (14) of the incest experience. She describes sensations, smells, and then, where memory fails, a state of spontaneous dissociation: "Then I don't remember. I roll myself into a little ball and go way deep inside myself to hide. There's a place in my lower belly that's black – dark and safe. I make myself very small and hide there . . . until I hear Grandpa leave the room" (14). Lydon's account of going inside herself is a typical representation of immediate traumatic response. The dissociation that she describes here is a hallmark of traumatic experiences and closely resembles psychiatry's empirical discourse. As Herman explains, when a person is powerless in a certain situation, when she realizes that resistance is futile, she may go into a state of surrender and escape the situation by altering her consciousness (42).

This kind of dissociation, which drugs also produce, can become a recurring response to the "intrusive reliving" (Herman 47) of the traumatic experience. (Such "intrusive reliving" is a symptom of PTSD.) Children who have been abused or severely punished develop the capacity for dissociative states into what Herman calls "a fine art" (102). "Dissociation thus becomes not merely a defensive adaptation but the fundamental principle of personality organization" (Herman 102).

Whether Lydon was familiar with this key psychological tenet of childhood trauma when she recorded her experiences, her assessment of the impact of incest on her personality supports the idea that trauma and responses to trauma fundamentally affect personality. Lydon's account of incest, and of herself as a child, reflects an almost clinical or expert awareness of psychology and psychiatry's concept of dissociation as an adaptive response to trauma as well as a "fundamental principle of personality organization" (Herman 102). After all, Lydon works to establish a clear relationship between her experience of multiple traumas and her personality and psychology, and, in turn, to infer a relationship between this relationship and her addiction.

I do not intend to devalue Lydon's subjective experience of these events by suggesting that her descriptions and evaluations of her experiences of incest and other traumas resemble and reproduce empirical and clinical psychiatric and psychological discourses of trauma. I do think, however, that the clinical overtones of Lydon's descriptions and assessments of incest lend a kind of authority to her voice and anticipate a similarly clinical theory and medical narrative that links trauma and drug addiction. Lydon's account of the trauma of incest, which evokes Herman's suggestion that dissociation is not only "a defensive adaptation but the fundamental principle of personality organization" (102), foreshadows and contextualizes Lydon's drug use as dissociation and as a means by which she keeps the dissociative but adaptive personality structure that she developed as a traumatized child intact.[6] In this instance, then, Lydon's drug use and addiction map onto her trauma narrative, or fit into the psychological categories of behaviour and personality that she establishes through her accounts of trauma. What begins to emerge, therefore, is the notion that Lydon's drug addiction is a symptom of her traumatic childhood.

Lessons of An Abusive Father

Incest is not the only interpersonal trauma that Lydon endures as a child; she also experiences physical and emotional abuse at the hands of her father. While Lydon's frank discussion of these private experiences of abuse can be read as a feminist gesture akin to consciousness-raising, her articulation of this abuse as traumatic is another product of the feminist intervention in trauma theory to include women's everyday, interpersonal experiences. Again, Lydon's conceptualization of her addiction as a response to trauma depends on the feminist conceptualization of physical and emotional abuse as legitimate traumas.

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[6] In their article, "Treating Women Drug Abusers Who Were Victims of Childhood Sexual Abuse" feminist therapists Mary Jo Barrett and Terry S. Trepper explain that "drug use in adulthood may be part of a progression in the coping mechanisms of sexually abused children, encouraging them to seek out the dissociation-causing effects of drugs in a way similar to those in which they psychologically dissociated when they were children" (129).

Her description of her relationship with her father immediately follows her memory of the incestuous and dissociative moment with her grandfather. She begins the story of her relationship with her father not with an analogous scene of assault, however, but with a second-hand recollection of their first meeting and a therapeutic analysis of this encounter. She recalls,

> I was two and a half when my father came home from the war. The first thing I did, according to my relatives, was tell him to take his hands off my mother's pajamas, and this was how our troubles began. My father, sensitive as a child, seething with feelings he couldn't express, believed I had rejected him. . . I, in turn, felt rejected by him. . . .[I]n that delicate readjustment so many soldiers experienced postwar, he wasn't conversant in the psychological knowledge that it might take time and patience to bond with a small child who viewed him as a stranger. (14-15)

As a preface to descriptions of the physical and emotional abuse that her father inflicts on her, this passage initially struck me as oddly compassionate, even generous. Lydon conveys this tone by evoking the notion that childhood experiences unequivocally determine adult behaviour, which is a central tenet of the popular conceptualization of trauma within contemporary therapeutic culture. Of course, Lydon's trauma narrative is rooted in her childhood experiences; but, here, Lydon returns to her father's childhood as a prefatory explanation of his abusive behaviour. This recollection of her father's childhood exemplifies "the premise that the early emotional experience of a child will determine and define behaviour in later years" (Furedi 29). Certainly, this foundational "truth" of therapeutic culture and the popular discourse of trauma can be criticized as "intensely deterministic" (Furedi 29). The claim that, as Furedi puts it, "the emotional damage suffered by children can constitute a life sentence" (29) contributes to a reduced sense of personal responsibility. Indeed, Lydon comes uncomfortably close to excusing her father's abusive behaviour by describing him as a "sensitive," pained child.

Conventionally, this deterministic (re)turn to childhood pain also precludes questions of social responsibility and erases broader social and political conditions that contribute to abusive environments and behaviours. In this instance, however, Lydon's characterization of her father's behaviour as part of "that delicate readjustment so many soldiers experienced postwar" (15) arguably counterbalances this tendency; Lydon's reference to "the war" (World War II) and postwar experience provides a broader political context for understanding her father's behaviour. The political context of war shifts the focus of this prefatory causal narrative of trauma from individual psychology to the relationship between political conditions and social behaviour. And although Lydon does not go as far as to suggest that her father suffered some kind of post-traumatic stress from his experiences of war, the well-established association between war and PTSD is evoked here, which links Lydon's feminist trauma narrative to its historical predecessor – war-related narratives of trauma. Overall, this passage introduces the reader to Lydon's almost dualistic approach to conceptualizing and interpreting the physical and emotional abuse she suffers at her father's hands; while Lydon emphasizes the psychological factors and implications of abuse, often using the language of psychiatry to do so, she also makes small but significant interpretative gestures that move the problem of abuse beyond an individual, therapeutic perspective to a larger sociopolitical framework (Root, "Reconstructing" 238).

Moving from this contextualization of her relationship with her father, she goes on to describe the abuse and its formative psychological consequences: "He was . . . quick to anger; he hit me a lot, which made me think he didn't love me. That was the great sadness of my life" (16). Verbal attacks often accompanied his physical violence: "My father was always telling me how stupid I was" (17). Lydon recalls, "The humiliation and stinging shame of my father's sarcastic barbs were worse than the physical pain of his spankings. . . . Each new putdown added to my feelings of rejection and worthlessness, eroding my fragile self-confidence" (17). As is typical of abused children, Lydon blames herself for her father's unhappiness (Lydon 16), and, as a child, she sees his behaviour as a consequence of her innate inadequacy and badness (Herman 105).

She makes two definitive assessments of the impact of her childhood relationship with her father. First, she explains that her father's tyranny made her resentful of male authority in general: "The arbitrariness of my father's absolute authority made defiance grow in me like a weed; to this day I have trouble doing anything I have to do and resent taking any kind of orders from a man" (21). Second, Lydon's relationship with her father shapes her understanding of love: "If this was love, then love came mixed with a big dose of violence; that was the message I got. Love meant rejection and brutality; ultimately it was unattainable; you had to work to get it, and chances were, you'd fail" (21). These statements may seem peripheral to Lydon's narrative of trauma as it relates to her addiction, but, in fact, they reveal the origins of attitudes and behaviours that Lydon sees as central factors of her addiction.

Lydon's defiance of male authority recurs in complex ways in relation to her addiction, which I discuss shortly. Her drug use in some ways represents a negotiation of a gendered binary of power. The necessity of such negotiation, Lydon shows, is born of traumatic experiences, such as physical and emotional abuse, which shape her understanding of herself as a girl and a woman.

The second governing effect of her father's abuse – the negative model of love – is also a trope in Lydon's story of addiction. The failure of love not only produces emotional pain that leads Lydon to seek the anesthetizing effects of drugs. The pursuit of this kind of destructive relationship is, in psychiatry's terms, part of "the signature of trauma" (Root, "Reconstructing" 242). In fact, this pursuit constitutes its own pathology according to popular therapeutic discourses. Women telling their stories of substance dependence in the late twentieth and early twenty-first centuries frequently describe men or romantic relationships as their "first addiction" or a concurrent addiction. Lydon remarks, "I was addicted to men before I was hooked on drugs; the drugs were a relief from that" (195). Later on, she cites her experience of reading *Women Who Love Too Much* as "one of the main reasons I had agreed to go to treatment. . . I knew I had an addiction to men, and the book had convinced me that it was progressive and fatal, following the same downward spiral as my addiction to drugs" (226).[7] Throughout her memoir, Lydon chronicles romantic relationships with men that replicate the dynamics of her abusive relationship with her father. Such duplication, psychiatry suggests, is a common effect of child abuse. Herman explains,

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[7] This issue of "love" or "relationship addiction," often used interchangeably with the concept of "codependence," is certainly relevant to women's issues of addiction. After all, these so-called addictions are commonly constructed as "feminine maladies" (Haaken, "Women" 241). They are also conceptualized as

> Because the inner sense of badness preserves a relationship, it is not readily given up even after the abuse has stopped; rather, it becomes a stable part of the child's personality structure. . . .The profound sense of inner badness becomes the core around which the abused child's identity is formed, and it persists into adult life. (105)

Lydon's own assessment of the impact of her relationship with her father echoes Herman's assertion that "repeated abuse is not actively sought, but rather is passively experienced as a dreaded but unavoidable fate and is accepted as the inevitable price of a relationship" (112). Again, Lydon draws on the psychiatric discourse of trauma to provide a context for understanding her adult pursuit of abusive relationships with men, a behaviour that she sees as a kind of addiction itself as well as a central part of her experience of drug addiction.

In her account of "the phenomenon of repeated victimization" (112), Herman explains that "many survivors have such profound deficiencies in self-

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"diseases," "based on an extension of the disease of model of addiction advanced by Alcoholics Anonymous to conflictual interpersonal dependencies" (Haaken, "Women" 241). Although they share this Twelve-Step rhetoric and therapeutic framework with substance dependence, "love addiction" and codependence raise a host of issues that are beyond the scope of this project. For discussions of women and codependence and "relationship" or "love addiction," refer to Robin Norwood, *Women Who Love Too Much*; Stanton Peele and Archie Brodskey, *Love and Addiction*; Ann Wilson Schaef, *When Society Becomes an Addict*; John Steadman Rice, *A Disease of One's Own: Psychotherapy, Addiction, and the Emergence of Co-Dependency*; Leslie Irvine, *Codependent Forevermore: The Invention of Self in a Twelve Step Group*; Elayne Rapping, *The Culture of Recovery*; Susan Faludi, "It's All in Your Mind: Popular Psychology Joins the Backlash" in *Backlash*; Janice Haaken, "Women, Recovery Groups, and 'Love Addiction.'"

protection that they can barely imagine themselves in a position of agency or choice" (112). After twenty-five years of problematic drug use (Lydon 223), having been repeatedly victimized by men, this is certainly an accurate description of Lydon, and it, in part, accounts for the difficulty of discontinuing drugs and imagining recovery. As a child and adolescent, however, Lydon compares her father's authoritative role to her mother's passive role and decides that she "preferred his" (Lydon 22). In fact, Lydon constructs her mother's model of femininity as a kind of trauma, which brings us to the second significant feminist contribution to trauma theory: the concept of insidious trauma, and, more specifically, the notion of sexism as an insidious trauma.

Insidious Trauma

Developed by feminist therapist Maria Root, the concept of "insidious trauma" refers to the "traumatogenic effects of oppression that are not necessarily overtly violent or threatening to bodily well-being at a given moment but that do violence to the soul and spirit" (Brown 107). In her article, "Reconstructing the Impact of Trauma on Personality," Root explains that "insidious trauma is usually associated with the social status of an individual being devalued because a characteristic intrinsic to their [sic] identity is different from what is valued by those in power, for example, gender, color, sexual orientation, physical ability" (240). Unlike conventionally defined trauma, which occurs as a "direct blow" (Root, "Reconstructing" 238), insidious trauma is "often present throughout a lifetime and may start at birth" (Root, "Reconstructing" 240). And while direct traumas, including such diverse experiences as combat and sexual abuse, shatter assumptions about the world, insidious trauma shapes a worldview (Root, "Reconstructing" 240). Root writes,

> As a rule, insidious trauma's effects are cumulative and directed toward a community of people. In effect, it encompasses some very 'normative,' yet nevertheless traumatic experiences of groups of people. Insidious trauma incurred by minority groups usually starts early in life before one grasps the full psychological meaning of the maliciousness of the wounds, for example, a child is told he or she is not the right kind of person to play with – too poor, wrong color, etc.. It does not typically include physical violence, yet leaves a distinct threat to psychological safety, security, or survival. (240-41)

Over time, Root argues, insidious trauma "may result in a picture of symptomatology similar to that of direct . . . trauma, particularly involving anxiety, depression, paranoia, and substance abuse" ("Reconstructing" 240). She continues,

> The frequency of insidious trauma results in a construction of reality in which certain dimensions of security are not very secure; as such, the individual is often alert to potential threat of destruction or death and accumulates practice in dealing with threat, especially insidious experiences like ageism, homophobia, racism, and sexism. Subsequently, activation of survival behaviors, heightened sensitivity, paranoid-like behavior, and hostility are frequently observed in response to seemingly 'minor' stressors by outsiders. In effect, the sensitized individual tends to risk false positives. (241)

Root identifies three types of insidious trauma. "One type includes, but is not limited to, racism, anti-Semitism, poverty, heterosexism, and ageism" (Root, "Reconstructing" 241). Sexism, the systemic oppression of women under patriarchy, fits into this first category. The formulation of insidious trauma to describe women's everyday experiences of systemic sexism has been one of feminism's most significant contributions to the study of trauma. I have found this notion especially useful for thinking about why women who do not experience direct, now-readily acknowledged traumas such as incest and physical abuse nonetheless construct a psychological self in their life stories that bears "the signature of trauma" (Root, "Reconstructing" 244). Whether or not the women have a history of abuse, they commonly describe a governing sense of alienation, inherent badness, and helplessness, which, according to Herman and psychiatry more generally, typically characterizes the traumatized person (Herman 52, 103, 105). While I recognize the danger in reading (diagnosing) these feelings as (medical) symptoms of post-traumatic stress, the idea that systemic oppression can be experienced as a kind of trauma goes some way towards explaining such consistent self-portraiture.

The Insidious Trauma of Sexism and Femininity: Lydon's Maternal Inheritance

In the stories of addiction I read in this project, the traumatic effect of sexism is most evident in the women's negotiation of femininity. Coming into a consciousness of her gender during the 1950s, a decade known for its "polarized and heightened conceptions of masculinity and femininity, as men returned from the war to resume their jobs, and women workers were displaced" (Haaken, "Women" 249), Lydon recognizes the femininity that her mother models as oppressive and psychologically damaging. She shows that the roles offered to and expected of her as a girl and woman lead her to see herself as powerless and unimportant, except in the service of men: "I learned from my mother that a woman's worth was determined by her sexual attractiveness, her ability to cater to a man and keep him happy, no matter what" (Lydon 22). When Lydon pursues her own interests, her mother calls her selfish: "It was a woman's role to sacrifice for others, especially for her husband and children" (Lydon 22). Lydon describes her mother's "betrayal of [her children's] interests," especially when "they conflicted with [her] father's" (22). She adds, "My father talked to my mother in a mean and condescending way and often called her stupid, as he did me, but she never answered him back or disagreed with him. . . . Sometimes when he upset her she took it out on us" (22). Yet, she summarizes her mother's position within the marriage and family as one of "martyrdom," and decides that "if [her] mother's martyrdom was the price marriage exacted from a woman, then [she] wanted no part of it" (22).

Observing the unequal balance of power in her parents' marriage, Lydon "found it impossible to model [her]self after [her] mother" (Lydon 22). She writes, "I wanted to function in a larger world than the one I'd grown up in, to wield at least an equal amount of power to a man's, to have the freedom to speak my mind and determine the circumstances of my own life" (22). She theorizes that the contrast that she observed as a child between her parents' gender(ed) roles "set up a tremendous . . . internal conflict for [her]" (22): "By rejecting my mother's values, which I couldn't help but internalize, I went to war not only with society, but with my inmost self" (22). Lydon's female identity, then, develops within a familial as well as a cultural framework that devalues women, and she recognizes that these contexts and constructs of femininity shape her worldview. She perceives the effects of the female roles that she learns from her mother as analogous to the feelings of worthlessness and shame her father's abuse inculcates in her. This maternal inheritance – learned helplessness and self-sacrifice – foster and reinforce Lydon's sense of inadequacy and isolation, feelings that she repeatedly links to her drug use.

Trauma, Gender Conflict, and Women's Drug Addiction

Lydon's later depiction of herself as a street-savvy "junkie" reveals a more complex relationship between this insidious trauma and other traumas, her gender identity, and her drug use. Clearly, the direct trauma of her father's abuse and the insidious trauma of her mother's model of femininity have a significant impact on Lydon's gender identity. Although she prefers her father's role over her mother's (Lydon 22), Lydon is committed to the notion of essential womanhood (83). She recognizes that she suffered from her father's misuse of power (Lydon 22), and she is defiant of male authority and rejects female passivity. Rather than simply identifying the childhood trauma inflicted by her parents as etiological factors of her addiction, she sets up *the internal gender conflict that these traumas created* as a factor of her addiction. Lydon's drug use and addiction represent a negotiation of this gender conflict. Moreover, this conflict over gender identity – the governing effect of her childhood trauma – links Lydon's narrative of trauma with a discourse of women's drug addiction that emerged in the 1970s alongside second-wave feminism.

Prophetic of the feminist backlash, critics in the 1970s began implicating feminism and its calls for gender equality in apparently increased rates of drug and alcohol use among women.[8] Feminism, critics claimed, created a conflict "between the self and social roles that generated tension and anxiety" (Parker qtd. in Babcock) and/or "identity confusion," which propelled women into drug use and addiction (Campbell 27). In her 1972 relic of anti-second-wave sentiment, "The Female Drug Addict and Her Feminine Mystique," Maureen McCarthy contends that women, who because of feminism are "no longer certain of the cultural norms or their own normality," can be expected to "experience psychological turmoil . . . [and] resist change, responsibility and pressure" (31), and thereby "succumb" to drug use and addiction (32).

An odd but typical slippage then occurs in McCarthy's argument whereby drugs supplant feminism as "the betrayer" of an essential femininity:

> The feminine mystique of the addict is petrified, for her mind and emotions become neutralized rather than sensitized. Drugs are the subtle betrayer of the feminine mystique in that they produce apathy and alienation, reduce ability to appreciate beauty and life and sharply curtail or destroy experiences of genuine concern, joy, warmth and love. (32)

Drugs, in other words, violate women's supposedly inherent sensitivity, empathy, and emotiveness and their subsequent social roles as nurturers, which in this interpretation is unequivocally bad for society. (This notion persists today, as we will see in the next chapter where the most grievous problem addicted women on *Oprah* face is the loss of emotion, which apparently obliterates their "maternal instinct"). Drug-addicted women do not simply violate gender norms by participating in the so-called "male game" of "drug culture" (Jonnes 383); the locus of the challenge to patriarchy posed by drug-addicted women lies in their apparent refusal to take responsibility for social reproduction.

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[8] See Marguerite Babcock's "Does Feminism Drive Women to Drink? Conflicting Themes" for a list of research from the 1970s to the mid-1990s that links "changing sex roles" to increased addiction among women. Also see Lindsy Van Gelder's, "Dependencies of Independent Women" in *Ms.* (February 1987).

Parallel assumptions about the relationship between women's "new" and "liberated" roles and rates of addiction are at work in Mark Boal's 2003 *Glamour* article, which I discuss in the next chapter.

This logic has also been inverted to construe women's drug use as an active challenge to patriarchy. "The female 'junkie,'" writes Elizabeth Ettorre in *Women and Substance Use*, "is the embodiment of a woman who rejects her femininity. In reality she is a 'non-woman' in the public sphere and her visibility is a direct challenge to the established patriarchal order" (12). After all, "the female addict embodies an 'impulsive self' who shirks" (Campbell 4) her culturally assigned responsibility for social and biological reproduction "while giving free rein to her desires" (Campbell 4). To some feminist critics, then, "addiction is a symptom of a woman's backlash against the disciplinary regimes that have contained her expressive desires and wills" (Friedling 4).

This is not to say that Lydon, or other women, use drugs and become addicts as a conscious or deliberate strategy against patriarchy, although clearly some feminist approaches have "valorized addictions as liberatory rhetorics" (Friedling 4).[9] Nor do I mean to suggest that the abuse that Lydon suffered at the hands of her father led her to use drugs as an act of insubordination. Likewise, Lydon's drug use cannot be read as a direct response to the insidious trauma of inherited femininity or as a rejection of the passive female roles her mother models. Nonetheless, Lydon finds a kind of "masculine" power in her drug use.

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[9] Women's addiction has been valorized as "liberatory rhetorics" in much the same way that "hysterical symptoms" have been read as "subversive in their rejection of the symbolic order of patriarchy" (Friedling 4). Problematically, this strategy insists on female suffering as the prerequisite for feminist agency (Friedling

In the early 1980s, Lydon learns to navigate New York's Lower East Side and its infamous "dope supermarket" (Lydon 163), a "violent and dangerous . . . landscape of devastation" (Lydon 164). She writes,

> I caught on quick; it's amazing what a good teacher desperation can be. And then I got to like it. Street life is seductive. I enjoyed making it in this man's world, full of macho posturing, where a woman had to be strong to gain respect. I felt I'd become tough and fearless, and in my best moments thought of myself as a *macha desperada*, some kind of feminist heroine with the outlaw mystique of the Wild West, which this urban jungle so closely resembled. (164)

"Making it" in this culture of drug use and trafficking certainly represents a violation of women's "proper" roles. More interestingly, however, the masculinity that Lydon performs in this "man's world" also exceeds social conventions; defined by an excessive posturing of virility and his "outlaw" status, the *macho desperado*'s power is marginal and tenuous. After all, this figure is also racially marginal. Lydon's claim to the role of "feminist heroine," therefore, awkwardly depends on the challenge she poses to patriarchy by violating normative femininity as a drug user and dealer,

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3). Furthermore, as Friedling argues, "Such feminist interpretation of addiction . . . as symptomatic of patriarchy or as uniquely *female* symbolic forms of protest perpetrate *a recovery* model of social change that reinscribes a prerequisite submission to therapeutic discourses" (5).

which, in New York's Lower East Side, requires the performance of an excessive and, in Lydon's case, Hispanic masculinity. Nonetheless, Lydon clearly feels empowered by this performance and her participation in this scene; she enjoys being recognized as a "strong," "tough and fearless" (164) *woman*.

Somewhat paradoxically, Lydon also learns that she must disguise her femininity on the street:

> I'd developed a different, tougher walk and had taken to wearing men's clothes all the time so I wouldn't attract any sexual attention when I was out on the street by myself late at night. I'd get my father's old flannel shirts, which my mother had washed so many times they were soft and comforting, and I wore my jeans and running shoes and a black leather jacket with my hair in a ponytail tucked in the collar. (165-66)

Because femininity signals sexuality, or "sexual availability," which renders Lydon vulnerable to violence, she literally puts on masculinity to protect herself. Again, her drug addiction, or her identity as an addict, requires a performance of masculinity. Most strikingly, Lydon brings her parents back into the negotiation of gender as it plays out in her drug use. The description of her father's shirts evokes both the authority of her father's masculinity and the self-sacrifice and nurturance associated with her mother's femininity. Lydon embodies her father's authority when she wears his shirts on the street, but the tyranny and brutality of (t)his masculinity are tempered – made comfortable for her – by her mother's stereotypically female, domestic act of laundering. Lydon's addict identity, therefore, is a site for her negotiation of the gender conflict that she identifies as a consequence of the direct and insidious traumas of her childhood.

Transgenerationally Transmitted Trauma: Lydon's Jewish Inheritance

Gender is not the only conflictual aspect of Lydon's identity that is both a legacy of an insidious trauma and an important part of her addict identity. As we have already seen, Lydon's addict identity incorporates a sense of racial otherness. This racial marginalization evokes the second type of insidious trauma that Root identifes: "the transmission of unresolved trauma and attendant defensive behaviors and/or helplessness that is transmitted transgenerationally as the result of an ancestor's direct trauma" ("Reconstructing" 241). Root cites the Holocaust, the Japanese-American internment during World War II, the removal of Native Americans from their homelands, and many refugees' experiences as examples of direct traumas whose legacy includes the transgenerational transmission of trauma (241). In such instances, Root asserts, "The experiences of the previous generation result in the teaching of worldview that incorporates the traumatic experience" (241).

Lydon's representation of her Jewish[10] identity and inheritance persuasively illustrates the notion that trauma can be transmitted transgenerationally. In a strikingly literal example of the transgenerational transmission of trauma, Lydon recalls visits with her "unrelentingly critical . . . , sarcastic" (15) and melancholic (15) Jewish paternal grandmother, Mama Yetta, where the two looked, through tears, at photographs of relatives who had died in Europe: "She . . . impressed me with the tragic word, refugee. I identified with the sad-eyed refugee children . . . and I felt like an outsider, not a real American. This feeling of being on the outside looking in would become a hallmark of my life and my addiction, recurring like a musical refrain, 'I don't belong 'here'" (15-6). When Lydon and her family move from the Bronx, where "a taste for ethnic diversity [was] imprinted in [her] psyche" (19), to the upper-middle-class suburbs of Island Park, New York, her sense of estrangement intensifies. Mixing tenses, Lydon blends adult hindsight with her childhood perspective: "My identity had been forged in an earlier environment, deep down inside I'm still a displaced person, a little refugee child in my heart" (20).

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[10] I have identified the women whose stories I read in this project as white; however, Jewishness complicates this distinction. As Ann Pelligrini suggests, there is an "ambivalence surrounding the imagined racial otherness of the Jew" (cited in Friedling 65). In the history of racial sciences, the Jew has been characterized as "black," as "white," and as "*Mischling*" ("half-breed") (Friedling 65): "Perhaps it is possible to make only this qualified claim," writes Pelligrini, "the Jew was not 'white,' but was rather. . . 'off-white'" (qtd. in Friedling 65). Friedling concludes, "As a kind of third term, Jewishness may represent the crisis of racial definition" (65). It is beyond the scope of this project to theorize the ambivalence of Jewishness, but I want to acknowledge that Lydon's struggle with this ambivalence plays an important part in her conceptualization of her addiction. See Chapter 3, "Funny, She Doesn't Look Drew-ish: Jewish Addicts and the 'Truth' of Recovery" in Friedling's *Recovering*

Lydon suggests that this kind of insidious trauma and its transmission begin even earlier than her own childhood. She explains that her great-grandfather, a defector from the Rumanian army, changed their name to Goldenberg to cover up the desertion when he, his first wife, and their nine children crossed over the border into Austria-Hungary (10). Later, in America, her father changed their

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Women, for an examination of how Lydon, Elizabeth Wurtzel, and Kim Chernin "consistently reveal their own Jewishness and find images of suffering in Jewish history to account for their addiction" (60) in their autobiographies.

Also beyond the scope of this project, but worthy of note, Jewish feminisms have developed in response to the recognition of a doubled and often parallel oppression of Jewish women as both Jews and women (Friedling 61). See Koltun (ed.), *The Jewish Woman: New Perspectives*, Baskin (ed.), *Jewish Women in Historical Perspective*, Hyman, *Gender and Assimilation in Modern Jewish History: The Roles and Representations of Women.*

surname again, to Gordon, to "combat the anti-Semitism that he said prevailed in the business world" (10). Her mother's maiden name "was also made up" (Lydon 12). Lydon recounts, "When my [maternal] grandfather and his brothers passed through Ellis Island, immigration officials had difficulty understanding what they said and gave all three brothers different names. . . . They came from Argentina, where they had worked as gauchos after leaving Poland" (12). "So like many Jews of the Holocaust years," Lydon writes, "I had no real name, no traceable history" (10).

This loss, or, more accurately, this denial of identity and personhood represented by a familial name and history, also helps the reader understand Lydon's story as an attempt to recover a coherent identity within what Friedling calls the "generally circulating narrative of addiction" (Friedling 64). Naming is a privilege denied to Lydon (Friedling 66); addiction and Twelve-Step recovery offer her the possibility of a stable name and identity as well as the ostensible opportunity to name herself.

As Frieldling notes in her brief discussion of Lydon's autobiography in *Recovering Women*, however,

> Underwriting [Lydon's] claim to the addict identity is her affirmed Jewish inheritance that lends representational authority, collective memory, and a history of oppression to her addiction. Lydon claims that it is the historical event of Jewish annihilation and Diaspora that has shaped her consciousness and has led her to this need for recovery. (66)

"Even as a second-generation American," Lydon explains, "I was born into a history of pogroms and persecution, the remembered shame and deep suffering of generations of victims of violent crimes. I inherited fear and fatalism as surely as if it had been imprinted in my DNA" (12-13).[11] This description of her Jewish inheritance as transgenerational trauma intertwines a sociopolitical and historical context with a scientific discourse in the metaphor of genetic inheritance.

The overall effect of Lydon's conceptualization of this transgenerational trauma as both an inherent individual and historical symptom is ambivalent. On the one hand, by using "images of suffering in Jewish history to account for her addiction" (Friedling 60), Lydon moves the discourse of trauma outside of the individualized paradigm of psychopathology, which is emphasized in her analysis of her abusive and otherwise traumatic relationships with her parents, to a broader political and historical context. On the other hand, this aspect of Lydon's trauma narrative is highly deterministic and illustrates the cultural expectation that victims' suffering must be long and severe in order for the trauma and pain to "count" (Lamb 113). As an etiological factor of her addiction, this transgenerational trauma politicizes addiction by relating it to a history of oppression; but, at the same time, addiction is made to seem like an inevitable pathology of such history.

Lydon also suggests, however, that addiction, as a behaviour, is a kind of transgenerational trauma. Root's description of transgenerational trauma focuses exclusively on national, or racial and ethnic communal experiences, but it seems to me that the concept might just as readily apply to families with histories of addiction and/or abuse. "Unresolved trauma and attendant defensive behaviors and/or helplessness" (Root, "Reconstructing" 241) associated with previous generations of addictive and abusive behaviours are unwittingly passed on in familial environments. Before Lydon reveals her maternal grandfather as a perpetrator of sexual abuse, she introduces him as an alcoholic, and she speculates,

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[11] Lydon reiterates the legacy of her Jewish inheritance during her college years at Vassar, where she felt particularly alienated and increasingly depressed. Although she notes that everyone of her generation was having a "difficult time" (103) in 1970, after the "high hopes for transforming society had been dashed by the continuing carnage of the Vietnam War" (103), she returns to her Jewishness to explain her augmented misery: "After all, I was a wandering Jew of the Diaspora, unrooted wherever I went. I didn't have to think about my Jewishness . . . ; it was a permanent part of me, like my skin. Thanks to my ancestral history, I believed, I never quite felt safe anywhere, never felt really at home. I retained a persistent sense of being an outsider, marginal, rootless, and somewhat deprived" (103).

> If we inherit a genetic predisposition toward alcoholism or addiction, as some scientists contend, then my grandfather passed on to me . . . 'the wayward gene.' If alcoholism and addiction are learned behavior, as other experts believe, he provided the alcoholic family atmosphere that my mother unconsciously recreated with her own small brood. (13)

Once again, Lydon simultaneously evokes insidious, transgenerational trauma as a product of her social environment alongside medicalized concepts of genetic inheritance as well as social or environmental inheritance to construct a causal narrative of her addiction. This passage also raises the question of whether addiction as an illness (as opposed to a behaviour) might be theorized as a trauma, which leads us to Root's third and final kind of insidious trauma.

Illness as Trauma and the Question of Drug Addiction as Trauma

The third kind of insidious trauma Root describes rather vaguely as that which "may occur together with the experiences of significantly declining health, progressive debilitating illness, or a markedly decreased ability to function independently (e.g., in AIDS, diabetes, multiple sclerosis, some cancers)" (241). According to this definition, drug addiction could be understood as an insidious trauma. After all, addicts, including Lydon, certainly experience "significantly declining health," physically and mentally. And, in popular(ized) medical discourse, drug addiction is a "progressive," "chronic disease" (NIDA, "InfoFacts"). "Addiction," reads the (U.S.) National Institute on Drug Abuse FAQ webpage, "is a chronic disease similar to other chronic diseases such as type II diabetes, cancer, and cardiovascular disease" ("Addiction is"). Yet even among the clinicians, researchers and theorists who subscribe to this disease concept of drug addiction and/or accept that the eventual physical and mental debilitation associated with drug addiction may be experienced as a kind of trauma, addiction is not theorized as a trauma in and of itself.

Nonetheless, as I have suggested, psychiatry – the primary disciplinary domain of both trauma and addiction – recognizes multiple relationships between trauma and drug addiction. While much research focuses on traumatic events as precedent of drug abuse and dependence, researchers are also quick to point out that "the drug-using lifestyle increases the likelihood of additional traumatic experiences" (Zweben, Clark, Smith 328). Women's memoirs of drug addiction unfortunately confirm this theory. In Lydon's case, interpersonal violence intensifies dramatically as her addiction escalates. She becomes involved with a man, for example, who not only beats her "black and blue" (Lydon 189), but also teaches her "how to turn tricks" and "how to support [her] habit as a booster – a professional shoplifter" (Lydon 190), for which she is repeatedly jailed (Lydon 190). "I'd acquired a massive drug habit" (190), writes Lydon, "and a case of battered woman syndrome that at one time would have made my hair stand on end" (190). Using the 1970s feminist discourse of trauma and post-traumatic syndrome, Lydon constructs a direct relationship between her addiction and traumatic experiences that illustrates what psychiatry's "systematic studies"[12] have found – that "substance abuse itself increases the risk of exposure to traumatic stressors" (Zewben, Clark, Smith 333). Yet, trauma in Lydon's addiction narrative is most significant as that which precedes her drug use.

Likewise, psychiatry is primarily concerned with trauma as a causal factor of drug addiction. In psychiatry's terms, those suffering from psychological trauma use drugs in an "attempt to regulate their internal emotional states" (Herman 109). Psychiatry has long regarded psychoactive drug use as "a pathological soothing mechanism" (Herman 109). In this intertwined discourse of trauma and addiction, drug addiction is at once a self-preserving, adaptive response to trauma and a pathological symptom of it. This relationship between trauma and drug dependence illustrates one of feminism's major concerns with the conceptualization of trauma: the pathologization of "normal responses" to traumatic events.

Depathologizing "Normal Responses" to Trauma[13]

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[12] See Zweben, Clark, and Smith's "Traumatic Experiences ad Substance Abuse: Mapping the Territory" for a catalogue of studies in psychiatry that reveal "the high frequency of trauma in addicted populations" (327).

[13] I use quotations around this term, "normal responses" to keep the constructedness and malleability of the concept forefront. In "Trauma Talk in Feminist Clinical Practice," Jeanne Marecek notes that several respondents in her study liked the diagnostic category PTSD "because it embeds the idea that the women to whom it applied is [sic] normal" (167). "This is a paradox," she asserts, "that warrants further examination" (167). The term "normal" has multiple meanings when it is applied to psychological conditions (Marecek 167). As Marecek explains, "It can mean 'average,' that is, lying within a statistical range of the mean. . . It can also mean normal according to an absolute criterion. It can also mean 'not deviant[,]' . . . [which] often boils down to whether or not the speaker approves of

One of the most significant contributions of feminism to trauma theory, Root suggests, is its "depathologization" of "normal responses to horrible experiences that transcend daily and development hassles and struggles" ("Reconstructing" 237). She insists, "Disorganized and unusual behavior following horrible experiences are normal responses to traumatic events. Many of the behaviors we see after trauma are manifestations of specialized coping behaviors for survival, but are not usually recognized as such and thus are pathologized" ("Reconstructing" 237). Root argues for the reconfiguration of conventionally "negative symptomatology" (Horowitz qtd. in Root, "Reconstructing" 248) of post-traumatic stress as "survival behaviors" ("Reconstructing" 248). Behaviours such as social withdrawal, which are "conventionally viewed as regressive behaviors, signs of instability, or impaired emotional functioning, are cast [in a feminist perspective] as self-preservation behaviors, the presence of which indicates that the individual has the capacity for self-preservation" (Root, "Reconstructing" 248). The reconfiguration of unsettling post-traumatic behaviour as "normal responses" and/or "survival behaviours" affords the sufferer some degree of agency and authority, which has been historically denied to women through the concept of hysteria, for example, and, more generally, through social constructs of women as more vulnerable to mental illness and disease (Lamb 110).

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the behavior in question" (167). "In trauma talk," she argues, "the diagnostic category PTSD slides between different meanings of 'normal.' It asserts that a woman is normal even though she faces difficulties severe enough to warrant psychiatric diagnosis and problematic enough that she seeks treatment. Here it seems as if the third meaning of *normal* is the relevant one" (167). Therapists use the label "normal" to relieve their clients' shame, and to reassure clients of their approval (Marecek 167). I think Root uses the term similarly to reduce the stigma of psychiatric diagnosis and to allow the traumatized person to retain or regain a sense of agency. Still, I recognize the problems with naming "normal responses."

After enumerating her four main experiences of childhood trauma – incest, her father's physical and emotional abuse, her mother's model of femininity, the transgenerational trauma of her Jewish identity – Lydon performs an interesting inversion of her position as a victim that goes some way towards depathologizing her addiction. She asserts that her parents

> did the best they could with what they had. . . . What happened later in my life was not their fault. But there's no doubt that a childhood filled with shame, grief, and an overwhelming feeling of inferiority fertilized the soil in which my addiction could take root and grow; or that the adversity of my early life honed the skills I would need to survive it. (23)

With this last clause in particular, Lydon claims agency within her trauma narrative. By suggesting that her childhood hardships taught her how to survive the adversity of her adult life, Lydon inverts the expectation that such conditions simply perpetrate suffering. Trauma theorists would agree; the abused – or otherwise traumatized – child develops defensive psychological adaptations that become fundamental principles of her adult personality organization (Herman 102). Put simply, she uses the same coping mechanisms and skills that she learned as a child to deal with traumatic events or conditions of adulthood.

More than reinforcing well-established psychological tenets of traumatic response, Lydon's assertion that the "adversity of [her] early life honed the skills that [she] would need to survive" (23) her addiction preemptively recasts her behaviours, including her drug use, as "survival behaviours," as opposed to deficiencies (Nicki 82), or signs of instability or impaired and/or regressive emotional and psychological functioning (Root, "Reconstructing" 248). The trauma model allows Lydon to preserve her "essential normalcy and rationality" (Haaken, "Recovery of Memory" 1078) in face of not only the legacy of feminine hysteria, but also the stigmatizing discourses of illicit drug addiction.

The notion of depathologization arguably forms the crux of Lydon's use of trauma as the interpretative framework for her addiction; revealing the social and psychosocial origins and conditions of her drug use, Lydon's trauma narrative encourages us to see her drug addiction as the response to her multiple and varied childhood traumas rather than an individual psychological instability, moral weakness, or biomedical condition. The trauma narrative, in other words, is meant to depathologize Lydon's drug use and addiction.[14] In turn, the historically persistent, stigmatizing concept of drug addiction as psychiatric condition that epitomizes personal maladaptation and, in the case of women, inherent psychological weakness and deviance is also mitigated.

This is not to say, however, that Lydon or feminist therapists and clinicians deny that drug addiction constitutes its own (psycho)pathology that requires medical intervention. While Root argues for a recognition of women's drug use as a "method of coping . . . with the negative affect, images, and cognitions accompanying unresolved sexual trauma" ("Treatment" 546), she readily acknowledges that drug use frequently becomes "more intrusive or all-consuming than the original trauma" ("Treatment" 545).[15] The distinction between a "normal response" (or adaptive, survival behaviour) and maladaptive behaviour (or pathology) thus lies in the imprecise moment when the adaptive behaviour becomes more consuming than the trauma.

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[14] In some ways, the notion of depathologization is inherent to the concept of psychic trauma itself. The concept of psychic trauma represents a normalizing of psychiatric conditions that historically have been viewed as reflecting some form of personal maladaptation (Haaken, "Recovery of Memory" 1076). The original theoretical proposition of the PTSD diagnosis was that the response to trauma, as described by PTSD symptomatology, was essentially normative (Yehuda and McFarlane). Haaken notes, "While the assumption that pathological symptoms had an original adaptive value has historically been a tenet of psychoanalytic thinking, trauma theory goes much further in asserting the 'internal wisdom' and essential 'normalcy' of the patient's symptomatololgy" ("Recovery of Memory"1078).

Of course, the paradox here is that trauma nonetheless operates within the medicalized model of psychopathology; PSTD is a medical diagnosis, a pronouncement and classification of psychiatric illness.

Narratively (as opposed to psychologically), such moments are not actually all that imprecise. In Lydon's memoir, as in many stories of drug addiction, this transition from adaptive response to pathology is signaled by the prioritization of procuring drugs at the expense of all other activities. Drug addiction replaces her experiences of trauma as that which, in Lydon's words, had "sunk . . . [its] tentacles . . . deep into [her] psyche" (143). Trauma resurfaces, however, when Lydon is in recovery, when she is forced, as she writes, to "deal with feelings" that "the dope covered up" (246).

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[15] Root's use of "intrusive" alludes to a PTSD "symptom cluster" known as "intrusions" (Baldwin). Attempts to avoid or numb these intrusions are also part of the PTSD symptomatology. Thus, drug use and abuse, which is commonly recognized as such an avoidance behaviour, can be read as a symptom of PTSD.

PSTD symptomatology also includes "heightened arousal that may be demonstrated by hypervigilance, anxiety, sleep disturbance, or irritability" (Root, "Treatment" 545). David Baldwin offers this useful summary of the symptomatology of PTSD on his website, *Trauma Information Pages*: "the three main symptom clusters in PTSD [are]: Intrusions, such as flashbacks or nightmares, where the traumatic event is re-experienced. Avoidance, when the person tries to reduce exposure to people or things that might bring on their intrusive symptoms. And Hyperarousal, meaning physiologic signs of increased arousal, such as hyper vigilance or increased startle response" (http://www.trauma-pages.com/trauma.php#SYMP). For a discussion of the psychobiological mechanisms at play in these symptoms, see Bessel van der Kolk's "The Body Keeps Score: Memory and the Evolving Psychobiology of Posttraumatic Stress."

Conclusions: "Resolving" Trauma in Recovery

"Book One: The Making of an Addict" is characterized by Lydon's analysis of the material reality that laid the groundwork for her personal experiences of drug use and addiction (hooks 108). While she describes the psychological damage of her experiences of trauma, she also illustrates the interplay between her familial environment, socioeconomic and political conditions, and the traumas she suffers. For example, Lydon links the psychological effects of her father's abuse and her mother's subjugation to her pursuit of drugs' anesthetizing effects, but she recognizes that the difficult socioeconomic conditions of her parents' upbringing shaped their attitudes and expectations: "Both my parents, raised during the Depression in families with unhappy marriages and soul-destroying economic struggles, shared the same opinion about bringing up their children. . . . [S]o long as we were housed, clothed, and fed three square meals a day, we had nothing to complain about" (23).

Similarly, Lydon situates her escalating drug use, depression, and anxiety during her college years in the uneasy and tumultuous political climate of the early 1960s. For example, she writes, "I had been really depressed at the beginning of my sophomore year. It started with the Cuban missile crisis" (47). At the same time as Lydon's drug use metamorphosizes into a "nasty question of [her] drug problem" (53) against the backdrop of what she calls "revolutionary fervor" (89), she begins building an intellectual feminist framework that, she notes, "would provide stable ground . . . for years to come" (53). In this first part of her memoir, Lydon's discussions of the various traumas she endures, as well as the psychological sequelae of these experiences (such as depression), reflect a feminist commitment to revealing the sociopolitical context of individual, daily life and to understanding trauma and its sequelae as a sociopolitical problem.

In "Book Two: Abandon Hope, All You Who Enter Here," Lydon's drug addiction largely eclipses trauma as a distinct narrative, although Lydon accumulates further traumas as a drug addict. This portion of the book chronicles the details of Lydon's increasingly disturbing and destructive drug use. She becomes estranged from her family, including her daughter, Shuna; she cannot keep a job; she works the streets as a dealer and a prostitute; she is repeatedly assaulted, physically and sexually, by men she trusts; she has five abortions; she contemplates suicide. References to the political climate or sociopolitical factors that might have affected her experiences are noticeably fewer than in the first section, although she still notes broad socioeconomic conditions such as "the feminization of poverty" in the mid-to-late 1970s (148), which affect her as "a single mother struggling to support a child in New York City" (148).

This kind of social context disappears entirely in "Book Three: Getting Free," which focuses on Lydon's daily recovery routine of household chores and "dealing with feelings" (Lydon 234) at a live-in treatment facility called Women, Inc.. With its focus on Lydon's quest to heal her "wounded inner being" and construct a new, appropriately feminine self, "Book Three" reveals the power of recovery rhetoric to, in Rapping's words, "defuse the political tensions which fuel so much of what is now called 'addiction' by focusing only on the *effects* of our confusion and pain, not the causes" (7). This is not to say that Lydon's trauma and abuse experiences are not evoked as causes of her addiction in recovery. Indeed, the relentless pursuit of feelings – "experiencing and expressing them" (Lydon 246) – as well as psychological testing brings Lydon's childhood traumas, particularly incest, to the fore of the etiology of her addiction, but in a covert way;[16] it is, as Rapping suggests, the suffering, rather than the abuses themselves, that is the perceived cause of addiction. In Women, Inc., no one – not the counselors, not other addicts, not Lydon – even hints that the kind of emotional pain and behavioural effects produced by the traumatic events and circumstances that many of the women there share is systemic. Without getting into an elaborate (albeit warranted) critique of recovery rhetoric,[17] I want to examine one of the final scenes in Lydon's memoir where I see a troublingly subtle conclusion to her trauma narrative in her embodiment of "recovery."

Three years after completing the Women, Inc. program, Lydon moves to back to Berkeley, California – this time with her college-aged daughter, Shuna. One Friday night, Shuna asks Lydon if she could come with her to a Twelve-Step meeting where Lydon had been invited to "share, as they say, [her] experience, strength, and hope" (315). Lydon promises to pick up Shuna at her dorm and to bring her some stuffed cabbage (314). She then recalls the pleasures of helping Mama Yetta in the kitchen: "how to roll up the stuffing inside the cabbage leaves is in my fingers . . . imprinted on me as a child" (314-15). The dish comes out "delicious. . . ; it was Jewish soul food at its soothing best," Lydon remarks (315). Shuna eats the cabbage from a plastic container while Lydon shares her experiences with the group. At the end of the meeting Shuna comes "right up to the front of the room and [sits] down on [Lydon's] lap" and praises the cabbage as "absolutely the best food [she] ever ate" (316). Lydon responds, "I used to make it when I was pregnant with you" (316). Shuna then compliments Lydon on her "share" and adds, "You are a great woman. And I hope I grow up to be just like you" (316).

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[16] During two earlier and brief stays at separate treatment facilities, Lydon is administered the Minnesota Multiphasic Personality Index (MMPI) test. The first counselor tells her that she has "the total personality profile of a woman who's been sexually abused in childhood" (179), but Lydon cannot recall any abuse. The second test reproduces the results of the first. Just before Lydon enters Women, Inc., at another treatment facility, she mentions to a therapist that "both times [she'd] taken an MMPI, the psychologists has asked if [she'd] been a rape or incest victim[, but she] didn't remember anything like that" (229). The therapist leads her "back through guided imagery to scenes in [her] childhood, where [she] reexperienced the terror and shame of some sort of sexual assault" (Lydon 229). This experience marks the beginning of Lydon's recollection of incest.

[17] Recovery rhetoric has as its goal the recuperation of heteronormativity and the elimination of any transgressive potential that might exist in the figure of the addict. For feminist critiques of recovery rhetoric and the recovery movement, see Friedling, *Recovering Women*, Rapping, *The Culture of Recovery*, Kaminer, *I'm Dysfunctional, You're Dysfunctional*, Henderson, "Introduction: Feminism and Self-Help."

What threads of Lydon's trauma narrative recur in this concluding scene of "successful recovery," and what traumas are marked as "resolved" by such recovery? Successful recovery here is signaled by the recovery of "proper" femininity as a nurturing mother and by the recovery of a protective, caring Jewishness. Friedling notes, "Although the imagery of Jewish suffering, strangeness, and pathology inform [Lydon's] addict identity, a unified notion of the category of woman, its maternal essence, and a positivist notion of feminist history guides her recovery. The repairing and recovery of her Jewishness takes place through the valorizing of the maternal" (67). In terms of Lydon's trauma narrative, it seems that the insidious trauma of her Jewish inheritance is transformed through recovery from drug addiction via a recuperation of femininity, which is also an apparent resolution to the trauma associated with her femininity and gender conflict.

By the end of the memoir, there is neither a medical(ized) condition of addiction, nor a psychological symptomatology of trauma from which to recover. Moreover, it appears, there is no longer a culture of domination from which to recover. There is only "an authentic core" – an essential ethnicity and femininity – to recuperate from beneath the drugs and addiction. The rhetoric of recovery in the last third of *Take the Long Way Home* defuses the feminist politicization of Lydon's addiction as a response to the traumatic events and circumstances of her early life. As Ellen Driscoll writes in "The Politics of Recovery," "in the recovery movement paradigm, the social and political sources of oppression are so obscured that the political is now the personal, which is a dramatic reversal of the once powerful feminist dictum" (258). Indeed, the individualized therapeutic narrative of recovery at the end of Lydon's story threatens to undermine her earlier adherence to the feminist mantra, *the personal is political.* The recuperation of Lydon's addiction into individualized narratives of addiction, particularly via appropriate feminine identity, mutes the sociopolitical context in which her addiction arose. The end of the book suggests a capitulation to the demands of normative femininity that also mutes the reality of women's everyday lives, including experiences of both insidious and direct traumas. In other words, the connection between the personal and the political is nullified, or at least obscured.

Until this last third of the book, however, Lydon's trauma narrative frames her drug addiction as a feminist issue. Women's drug addiction has long been regarded paradoxically as an indication of women's "natural" psychological weakness, and as a remarkably psychopathic deviance. The feminist conceptualizations of trauma that Lydon draws upon to tell her story of drug use and addiction debunk both of these myths. Yet, reading her drug addiction as a both a distinctly non-pathological response to trauma and a post-traumatic symptom, Lydon leaves us with a different but parallel paradox: while women's drug addiction may be an adaptive response that foregrounds the impact of abuse and more insidious traumas, and therefore potentially recasts addiction as a social and political issue, as a *symptom* it still operates with the conventional medicalized model of addiction and, more broadly, psychopathology. In this configuration, the "validation" of drug addiction as a response to or manifestation of women's psychological pain threatens to become another therapeutic avenue by which the old idea of an inherent female vulnerability is reinforced (Haaken, "Recovery of Memory" 1083).

Yet, I am tempted to write something about how insightful I have found trauma theory, including the medical model of trauma and psychiatry's emphasis on the direct relationship between women's experiences of childhood trauma and drug addiction. Much of my earliest thinking about women's stories of drug addiction involved the concept of psychological trauma. The overwhelming majority of narratives that I read as part of my search for primary texts begin with recollections of particularly painful childhood incidents: severe beatings at the hands of parents, vague memories of sexual attention from fathers and other male relatives, cruel and constant verbal rejections from parental figures, and the death of a loving, protective guardian. I immediately noticed that the women in these stories share a self-professed governing sense of alienation and abandonment, and that, as they explain, drugs provide relief from this pain. In my early research, theories of trauma complicated my understanding of drug addiction as an exceptional, individual behaviour, and shifted my attention to the systemic conditions that led to the experiences of trauma that in turn led to women's drug use and addiction.

Nonetheless, I share with many feminist critics concerns about the contemporary ubiquity of the trauma model for making sense of women's experiences and pain. I recognize that "trauma talk," as Jeanne Marecek calls it, can be criticized for "subsum[ing] the particularities of a woman's experience into abstractions (eg., 'trauma,' 'abuse') . . . [,] reduc[ing] experience into discrete, encapsulated symptoms (flashbacks, revictimization) . . .[,] offer[ing] cause-and-effect explanations that are linear, mechanistic, and mono-causal" (Marecek 165). Certainly, I see how the trauma model "runs the risk of constructing women exclusively as objects of oppression" (Marecek 163). I appreciate that the equation of being victimized with having a chronic mental illness is highly problematic (Lamb 108). And, to some extent, I concur that, as Sharon Lamb argues, "our new medical conceptions of the ravages of trauma . . . reproduce a notion of girlhood or womanhood that we [North American culture] would like to preserve: the helpless female . . . who needs reviving . . . or rescuing" (112-13).

Moreover, I agree with Janice Haaken's claim that the "feminist embracing of the trauma model is symptomatic . . . of a much broader crisis within feminism regarding the sustained effects of victimization and our current difficulties in mobilizing meaningful resistances" (1088). As Lamb points out, at one point in the history of exposing abuse, it was politically important to advance lists of symptoms experienced by victims of sexual abuse, to force the public to take abuse seriously (111). But, as she succinctly puts it:

> discussions of power and dominance yielded to discussions of symptomatology and long-term effects. It was as if the most effective way to stop abuse or to make the public recognize the problem was to prove that abuse inevitably and overwhelmingly leads to psychological distress. There seemed to be no other reasons to bring a stop to the abuse of women and children... The wrongness of abuse could have been founded on some kind of universal or shared belief about how people ought to treat one another, instead of on the concept of psychological damage; and if it had, a movement directed at social and political change might have survived. (110)

Unarguably, we need to look critically at the contemporary cultural currency of trauma, which currently circulates without a distinct political movement.

Still, trauma theory intervenes in some of the most stigmatizing ideas about drug-addicted women. By revealing how women's capacity to assert meaningful agency in their lives is consistently undermined, trauma theory can expose the conditions under which addiction makes sense. Granted, psychiatry and its assertion of the etiological relationship between trauma and addiction does not make this jump for us, but feminism can.

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In their article, "Survivor Discourse: Transgression or Recuperation?" Linda Alcoff and Laura Gray-Rosendale caution that the dominant discourse will always attempt to silence survivor speech, "or, failing this, to channel it into nonthreatening
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outlets" (205). Around the same time of this article's initial publication in 1993, a body of literature examining the new cultural phenomenon of personal revelation and confession on daytime television talk shows emerged.[18] While some critics celebrated such revelation as akin to feminist consciousness-raising, given the shows' focus on women (Shattuc 93), others demonstrated how women's routine revelation of their intimate experiences of abuse, for example, represents the recuperation of survivor speech by the dominant discourse.

Some twelve years later, on two 2005 *Oprah* shows where white, middle-class, methamphetamine-addicted women tell their personal stories of addiction, trauma (and feminism) are conspicuously absent. In fact, unlike Lydon's story, Oprah's addicted guests' stories revolve around the absence of direct trauma. Yet, they are aware that the etiology of women's drug addiction commonly involves traumatic experiences such as abuse, and, without histories of direct trauma, they struggle to understand their addictions as responses to overwhelming emotional pain. Trauma has not exactly disappeared from these recent stories of addiction, then; these (auto)biographical narratives are constituted by a therapeutic code that reflects the mainstreaming of trauma and the prevalence of suffering as a trope of modern identity (Illouz, *Oprah* 90, 98). Focusing on how white, middle-class women construct themselves as addicts on *Oprah*, the next chapter examines the currency of "therapeutics" (Furedi 1) in white, middle-class women's stories of drug addiction and, in turn, the currency of the white, middle-class female drug addict in contemporary therapeutic culture.

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[18] See, for example, Jane Shattuc, *The Talking Cure: TV Talk Shows and Women*; Kathleen Lowney, *Baring Our Souls: TV Talk Shows and the Religion of Recovery*; Janice Peck, "The Mediated Talking Cure: Therapeutic Framing of Autobiography in TV Talk Shows."

Chapter Four

"Do I look like a drug addict to you?": The Contemporary Drug Addicted Woman in Popular Culture

Turning from her laptop and a small pile of notepads and books on a boardroom table, an attractive, well-groomed white woman in her mid-30s gazes pensively into the camera. With her head slightly tilted, her hands clasped lightly over the side of an office chair, and her slender legs decorously crossed, she appears confident and composed, polite and professional. Beside the woman, imposed on these black and white images of propriety, and enclosed in urgent yellow quotation marks, a headline reads, "Do I look like a **DRUG ADDICT** to you?" Beneath this caption, the woman's voice continues in smaller print: "Well, look again – because like 500,000 other women, I was seduced by the dangerous street drug meth. I even had it FedExed to my office. I was that addicted." The woman is finally identified in a tiny but sensational caption in the bottom left corner: "Meth kept Amy Hart skinny and successful – and then took all she had."

Thus begins an article published in the May 2003 issue of women's fashion and lifestyle magazine, *Glamour*. As with every "new drug" that becomes a media preoccupation, methamphetamine has brought with it not only the usual sense of urgency and claims of rapidly uncontrollable addictiveness, but also as usual "a more alarming group of users" (Campbell 38). The *Glamour* article, written by Mark Boal, profiles one of crystal methamphetamine's most disturbing supposedly new group of users: young, white, middle-class women. Alongside the customary citations of statistics, which suggest that overwhelming numbers of people spend astounding amounts of money on methamphetamine, and experts, who claim that methamphetamine is "one of the [U.S.]'s fastest-growing illegal drugs" (Boal 293), Boal interjects, "But what's most remarkable is that meth has made deep inroads into the female population" (293). "The female population" to which Boal refers in this homogenizing phrase is more specifically women with college educations, "impressive resumés" and "successful careers" (Boal 293) – women Boal calls "stylish strivers" (293) whose methamphetamine use is motivated by the need to be "superwife, superemployee, and super thin" (Boal 293).

Later in the article, to this list of "super powers" to which these women aspire, Boal adds "super mom" (314). Glossing over this obviously gendered role, Boal returns to the imperceptibility of the women's drug use and addiction, which the article's lead captions evoke. He quotes Myra Edgerton, a 36-year-old legal aide and mother of four whose turquoise jail garb pleasantly accentuates her blue eyes: "Just by looking at me, you would never have thought I was on drugs," she says (Boal 314). Another addicted woman's boss likewise remarks that she "had no idea [her computer programmer, Amy Hart] was on drugs" (Boal 314). Not surprisingly, Boal neglects to examine assumptions about gender, ethnicity, class, and the figure of "the drug addict" that operate in the invisibility of drug use among these women. After all, what makes these women spectacular – dramatic to look at – is paradoxically their invisibility and "normality." The point of the *Glamour* article is not to interrogate cultural assumptions about the roles and expectations of white, middle-class women, or to explore why these women explain their motivation for drug use as the pursuit of "superhuman powers" (Boal 314), as a feminist writer might. Instead, Boal's emphasis on the white, middle-class woman as an unforeseeable and ostensibly unrecognizable addict produces a sense of alarm. The article not only reinforces mainstream political discourse about illicit drugs as an insidious and ever-expanding threat, it also implicitly warns its readers – young white, middle-class women – that they too are susceptible to the "epidemic" of crystal methamphetamine addiction, especially if they aspire to be stylish and successful.

In *Using Women: Gender, Drug Policy, and Social Justice*, Nancy Campbell asserts that "the visibility of women's substance abuse shifts relative to patterns of social change" (23). White, middle-class women's drug use is particularly visible right now, even if it is cloaked in a rhetoric of invisibility, as the *Glamour* article demonstrates. What social conditions render white, middle-class women's drug addiction visible at this historical moment? This question guides my analysis of the figure of the female addict in this chapter. Today's female addict – again the young, white, middle-class woman – is almost invariably an object of therapeutic culture, conceptualized through discourses of self-help and emotion as well as medicine and science. Under therapeutic culture and the concurrent expansion of the concept of addiction, the female addict is arguably less demonized and stigmatized than she was in previous decades. The popular discourse of white, middle-class women's drug addiction largely reflects a cultural reconceptualization of "deviance" as "mental illness" – a reconceptualization that mainly applies to those regarded as "normal" to begin with. While addiction is popularly portrayed as a normal problem of existence (Furedi 123), sensationalism and notions of deviance still surface in contemporary representations of addicted women, primarily because drug use continues to signal a failure or a refusal of dominant norms of femininity.

My focus in this chapter is on *The Oprah Winfrey Show* as a key popular site of the white, middle-class female addict. I examine two shows: "Will She Choose Life or Death? An Oprah Show Intervention" (13 May 2005), and the follow-up show, "The 17-year-old Meth Addict: Did She Quit?" (28 November 2005). In comparison to *Oprah*, *Glamour*'s representation of the female addict is critically limited and limiting. Nonetheless, *Glamour*'s relative transparency functions as a useful basis on which to begin my discussion. Certainly, *Glamour* and *Oprah* are comparable in their treatment of drug addicted women; both explicitly relate women's drug use to the (failed) fulfillment of their prescribed gender roles, for example. They employ similarly propagandistic, sensationalistic, War-on-Drugs-reminiscent rhetoric to attribute "evil power" and absolute agency to crystal methamphetamine. And they both play on women's appearances of normality as a crucial and duplicitous feature of the addict identity. I will address some of these similarities, but *Oprah* is a richer text for my purposes because the main discursive practice routinized on the show is autobiographical storytelling (Illouz, *Oprah* 85). The centrality of autobiography on *Oprah* brings it generically in line with the rest of the texts I read in this project. Moreover, the show's imperative for (mostly) women to tell personal stories, and the therapeutic power with which the stories are endowed, raise many of the same questions I pursue throughout this dissertation. Namely, what must drug addicted women say about their lives in order to be heard? Can public self-disclosure be transgressive or empowering, or are these women inescapably subject to the normalizing imperative of the confession? Does the confessional process required of "the recovering addict" simply lock her in the grip of institutional and discursive control, or is something akin to feminist consciousness raising possible within this storytelling process? (Rapping 79, 87). What difference does it make if the women self-consciously address fellow sufferers and intend to help other women via their personal stories? How do the changing concepts of addiction – as a moral issue, as a social problem, as an individual psychological problem, as a biological illness, as a condition of everyday life – affect not only the format, but also the reception of women's stories? How do institutional discourses and expert voices get incorporated into women's autobiographical narratives and what effects do they have on women's constructions of their identity? Most broadly, how do these stories of addiction shape and reflect white, middle-class women as social actors?

I begin with a map of the competing and intersecting discourses that are at play in construction of the contemporary female drug addict and her life story. From there, I draw on Eva Illouz's analysis of *The Oprah Winfrey Show* to describe the show's therapeutic imperative. Analyzing shows from the late 1980s and 1990s, Illouz argues that "*The Oprah Winfrey Show* is a popular cultural form that makes sense of suffering at a time when psychic pain has become a permanent feature of our polities and when, simultaneously, so much in our culture presumes that well-being and happiness depend on successful self-management" (*Oprah* 5). According to Illouz, "Winfrey shows us how to cope with chaos by offering a rationalized view of the self, inspired by the language of therapy, to manage and change the self" (*Oprah* 5). Winfrey's therapeutic imperative overlaps with the popular therapeutic discourses of addiction and recovery; I aim to reveal the discursive links between the contemporary concepts of addiction and therapeutic culture, particularly as they get interwoven within *Oprah*'s therapeutic framework. Turning to an analysis of two recent shows, I examine how the therapeutic and self-help ethos that Winfrey espouses contextualize and complicate the representation of addicted women on her show. What does *Oprah*, as a popular cultural text, tell us about addicted women that other popular texts such as *Glamour* do not? How does *Oprah*'s therapeutic intent affect her guests' understandings of themselves as drug addicts and as women? And how does *Oprah*'s therapeutic ethos affect the audience's reception of these women as addicts?

The Female Addict in Popular Culture

Glamour and *The Oprah Winfrey Show* are both "popular culture texts" (Illouz, *Oprah* 60) aimed at similar female audiences;[1] as such, in one way or another, both "address social contradictions" and "provide a sense of direction for the [female] self" (Illouz, *Oprah* 61-2). Discussing the cultural creation of "popular texts," Illouz suggests that "texts are likely to be popular when they offer symbolic resolutions to social contradictions" (*Oprah* 61). She explains that "one of the characteristics of modern polities is that they are saturated with contradictions (between social spheres, norms, roles, and values), and that these contradictions in turn produce disorientation and difficulties for the self" (*Oprah* 61). Thus, "precisely because popular texts often address social contradictions, they are likely to provide a sense of guidance in a difficult and chaotic social order" (Illouz, *Oprah* 61). *The Oprah Winfrey Show*, Illouz asserts, "stages the central contradictions of identity and offers symbolic recipes to resolve them" (*Oprah* 62).

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[1] Given the fashion industry's fetishization of youth, *Glamour*'s intended audience is probably younger than *Oprah*'s, but both cultural texts are aimed at women as consumers of self-improvement. Close to 80 percent of *Oprah*'s audience is women (Illouz, *Oprah* 63), and, according to 2005/2006 Neilsen ratings cited in Winfrey's online biography, "the show is seen by an estimated 48 million viewers a week in the United States and is broadcast internationally in 126 countries" (http://www2.oprah.com/about/press/about_press_bio.
jhtml).

As a distinct popular genre, women's fashion and lifestyle magazines might be theorized similarly. Fashion magazines, however, are arguably less self-conscious about staging social contradictions than *Oprah*, and the "symbolic recipes" they offer are explicitly and often exclusively consumerist. Unlike *Glamour*, the "symbolic recipes" that *Oprah* provides exemplify the therapeutic ethos that characterizes contemporary North American culture, which I discuss further in the next section. As popular sites of the construction, dissemination and regulation of dominant norms of femininity, however, both texts can be said to "stage the central contradictions of identity" (Illouz, *Oprah* 62).

Norms of Femininity and the Female Addict

The figure of the female drug addict in popular culture not only functions as a symbol of social contradictions, particularly those of femininity; she crystallizes the equally conflicting social resolutions that are culturally prescribed for such contradictions. Campbell describes the figure of the female drug addict as "an overdetermined condensation symbol for a wide and shifting array of cultural anxieties" (14). I would suggest that the figure of the female addict is a "condensation symbol" for anxieties that especially relate to the changing social roles and contradictory expectations of contemporary women.

Following Campbell, I suggest that the *Glamour* article and the *Oprah* shows illustrate the connection between a presently elevated visibility of women's drug abuse and recent (and ongoing) shifts and contradictions in norms of femininity. Women's drug addiction is so visible at this moment because contemporary femininity is so fraught with contradictions: as part of the backlash against feminism and feminist critiques of women's confinement to the domestic sphere, motherhood has been reinscribed as women's most vital role; at the same time, women face continued social and economic pressure to work outside the home and "succeed" in the public sphere, as a mark of "equality." Correspondingly, contemporary femininity dictates that women be nurturing and emotive as well as independent and self-reliant. This is, of course, an oversimplification of the contradictions of normative femininity. Nonetheless, this summary identifies the main contradictions that the white, middle-class female addict embodies, particularly when she is understood as an object of therapeutic culture.

Although the *Glamour* article does not use the language of therapeutics to interpret or contextualize women's addiction (perhaps because it purports to be investigative journalism), its construction of the female addict navigates the transformations and inconsistencies of femininity. As my introductory account of the *Glamour* article suggests, Boal is not explicitly concerned with social transformation or the social and political factors of women's drug use and addiction. Yet, his description of women's motivations for taking methamphetamine – the need to be "superwife, superemployee, super thin" and "super mom" (293, 314) – depicts a recent important social transformation in women's normative roles. Boal's list of motivations is, in fact, a sketch of contemporary femininity. White, middle-class women are expected to continue to fulfill the traditional roles of wife and mother, and therefore continue to bear responsibility for biological and social reproduction, at the same time as they are expected to pursue careers and thinness, apparently with equal commitment. Of course, the pursuit of a career and the fact of having to "balance a career and a family," as the saying goes, are the more recent, late-twentieth- and early-twenty-first-century demands of normative femininity. The addition of the adjective "super" to these prescribed roles and aspirations is also a modern development; in keeping with the cultural demands of accelerated productivity and hyper consumption, women apparently must also strive for enhanced, "super" performances of their traditional and newer roles.

Boal also remarks that "now most women are more time crunched than ever, and some are using meth as an illicit career tool" (314). Again, the social transformation that Boal implicitly identifies here is women's participation in the public sphere. As Campbell notes, "once women confined to the private sphere were the problem; today it is women's participation in the public sphere that is questioned" (23). According to the *Glamour* article, the pressures of a career – "success" in the public sphere – cause women to take methamphetamine and thereby become criminals. In other words, "women's addiction is constructed as the product of individual women's inability to cope with changing versions of normative femininity" (Campbell 30).

Femininity is similarly central to *Oprah*'s treatment of addicted women. In the two shows I look at, the addicted guests are white, middle- or upper-class, suburban women, who by all appearances live comfortably in society and conform to their culturally assigned roles as wives and mothers. The women are all conventionally attractive. They are relatively thin. The majority of them have long blonde hair. They are immaculately groomed and wear heavy make-up and stylish, appropriately feminine clothing, as *Oprah*'s audience and guests usually do. In their physical appearances, the women embody normative femininity. Winfrey reinforces their normative femininity by introducing the women with labels such as "soccer mom," "stay-at-home mom," "mother of two," "all-American girl," and "PTA president."

These normative roles, among which motherhood is prized above others, are also a basis of drug use and addiction. That is, like the women in the *Glamour* article, addicted women on *Oprah* explain their motivations for using drugs largely in terms of their (in)ability to fulfill their "proper" roles. Of all the roles these women occupy, they most often cite "super mom" as the role facilitated by drug use. At the same time, in these women's minds, drug addiction automatically, unquestioningly signals a complete and disgraceful failure as a mother. Culturally, motherhood is deemed utterly irreconcilable with drug addiction. As Campbell succinctly puts it, "Women addicts' 'single claim to worthiness' lay in their enthusiastic embrace of the culturally prescribed role of the mother as the core of their feminine identity. Failing at this [is] tantamount to 'failing at womanhood in general'" (167).

When white, middle-class mothers become visible drug addicts, this violation of gender norms, which comprises a perceived disregard of their responsibilities for both social and biological reproduction (Campbell 172), "invite[s] attempts to govern women by targeting their behaviors and decisions" (Campbell 3-4). While popular culture does not "govern" in the way we think of legal policy or other juridical apparatuses as "governing," the increased visibility of addicted women in women's magazines or on television talk shows can be read as a mechanism of a broader cultural attempt "to govern women;" after all, *Glamour* and *Oprah* target women's behaviours and decisions and "provide a sense of direction for the [female] self" (Illouz, *Oprah* 62).

To reiterate, then, both *Glamour* and *Oprah* construct women's drug addiction as "the product of individual women's inability to cope with" (Campbell 30) the contemporary demands of femininity. *Glamour* identifies success in the public sphere, "balanced" with motherhood and the pursuit of the idealized female body, as the most (individually, as opposed to culturally) unmanageable demands of normative femininity and constructs these expectations as factors of women's drug use and addiction. The relationship that *Oprah* constructs between femininity and drug use, on the other hand, revolves around the domestic, private sphere. As Illouz explains, this focus on women's domestic roles is characteristic of the show: "Winfrey directly and unapologetically addresses women's lives inside the home, the daily tasks performed for and within the family, and aims at bestowing glory on these tasks" (*Oprah* 63). Winfrey expresses a reverence – "respect bordering on awe," says Illouz (*Oprah* 63) – for motherhood in particular. Addicted women on the show are subject to Winfrey's intended reverence of motherhood, which influences not only how the audience understands the women's addictions, but also how the women see themselves as addicts. Given the cultural demonization of mothers who use drugs,[2] the esteem with which Winfrey conventionally regards motherhood arguably contributes to stereotypical notions of drug-using women as morally reprehensible as well as to the women's sense of guilt about being "an addict." At the same time as being a mother renders the women's addictions shocking and especially troubling, it also marks these white, middle-class women as socially valuable and recuperable.

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[2] For discussions of the dominant cultural perceptions and representations of mothers who use drugs, see Drew Humphries, *Crack Mothers: Pregnancy, Drugs, and the Media* and Nancy Campbell, Chapters 6 and 7, "Reproducing Drug Addiction: Motherhood, Respectability and the State" and "Regulating Maternal Instinct" in *Using Women.* Also refer to Drew Humphries, et al.'s chapter, "Mothers and Children, Drugs and Crack: Reactions to Maternal Drug Dependency" in *The*

Glamour's construction of the relationship between femininity and drug addiction is typical of the popular culture discourse of women's drug addiction where white, middle-class women are seen as ill-equipped for their apparently more equitable (traditionally male) public roles, as we saw in the previous chapter. *Oprah*'s focus on women's more conventional roles complicates popular representations of women's drug addiction as a product of their "inability to cope with *changing versions* of normative femininity" (emphasis mine; Campbell 30), at least insofar as *change* entails a movement from the private to the public sphere. Of course, *Oprah*'s treatment of femininity arguably signals women's dubious return to the domestic sphere. The point I want to make here, however, is that in popular representations of addicted women, the locus of addiction is closely related to women's normative roles, whether they be conventionally private, public, or, more commonly, a "balance" of these now blurred spheres.

The notion that women's contemporary public roles as well as traditional private roles are problematic enough to contribute to drug addiction has the potential to be the basis of a feminist critique of mainstream representations of

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Criminalization of a Woman's Body (ed. Clarice Feinman). And for a more general discussion of women's reproductive rights, which the issue of maternal drug addiction inevitably raises, see Cheryl Meyer's *The Wandering Uterus: Politics of the Reproductive Rights of Women*, especially Chapter 3, "Politics and the Control of Women's Bodies."

women's addiction. That is, the perceived link between women's roles and their motivations for using drugs might, at the very least, encourage us to look critically at norms of femininity as detrimental, as a force that contributes to women's psychological and material motivations for using drugs.[3] Unfortunately, such interpretations are consistently undermined by an emphasis on women as *individually* unable to negotiate their normative roles. Despite obvious commonalities between the addicted guests on *Oprah*'s stage, for example, and despite therapeutic culture and the recovery movement's emphasis on community as a necessary condition of healing, addicted women are represented as individual actors, individually unable to fulfill their roles and manage their emotions and their lives, and individually responsible for their "individual choice" to take drugs.

Sensationalism, Normativity, and the Paradox of Visibility

A concomitant privilege of normativity, individuality also enables sensationalized representations of addicted women.[4] Indeed, representations of women's addiction in popular culture are often sensationalist, relying on the revelation and publicization of addiction as a "shameful secret" and an aberrant behaviour (Illouz, "'That Shadowy Realm'" 112). Even though addiction has been significantly normalized, when addicted women appear to exemplify femininity, when their addiction is therefore seen as an individual problem, they are often sensational figures, publicly shamed for and ashamed of the perceived aberrance of their drug use. Likewise, women's supposed failure in the public sphere is sensational when it is a correlative of their drug addiction. The *Glamour* article illustrates this phenomenon; its interpretation of women's drug addiction as the product of individual women's inability to handle the demands of work outside the home and to "balance" work with motherhood, and/or to maintain the pursuit of the idealized female body, renders women's addiction sensational – a shameful aberration of normative femininity that is worthy of public interest and excitement. *Glamour*'s emphasis on the unforeseeable and unrecognizable character of drug addiction among women who appear to conform neatly to the demands of femininity also contributes to the sensationalization of addicted women.

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[3] See my discussion of Maria Root's work in Chapter 3 in relation to Susan Gordon Lydon's trauma narrative. Root's notion of "insidious trauma," under which some of women's everyday experiences are understood as "traumatic," advances a critique of normative femininity. Moreover, Root links women's social roles and society's expectations of women, some of which qualify as "insidious trauma," to women's drug use and addiction.

[4] I understand sensationalism as a rhetorical strategy meant to provoke public interest and excitement, even agitation or anxiety. Illouz suggests that "sensationalism is characterized by the publicization of either the 'shameful secrets' of the rich and famous or of the aberrant behavior of ordinary people" ("'That Shadowy Realm'" 112-13). This definition is a useful guide. However, for white, middle-class women ("ordinary people"), drug addiction is sensationalized as both an aberrant behaviour and a "shameful secret."

At first glance, *The Oprah Winfrey Show* seems to sensationalize addicted women similarly.[5] Both texts invite the audience to gaze at these impossible addict figures in order to recognize that they misrecognize these women. Just as *Glamour* assumes that the words "DRUG ADDICT" will evoke stereotypical images of the poor, urban, downtrodden, perhaps violent, probably Black, and almost certainly male junkie, the poignancy of *Oprah*'s guests' stories also depends on the supposed unlikelihood of drug addiction in their lives. Like *Glamour*, recent *Oprah* shows that feature addicted women begin by drawing the audience's attention to the women's "normal" appearances and normativity, which is commonly signaled by their roles as mothers and wives. The emphasis on the women's normative femininity makes the revelation of their drug addictions especially dramatic; in conjunction with their whiteness and middle-class status, which, as a reflection of the privileges of normativity, need not be and are not mentioned, their "proper" femininity makes drug addiction unimaginable and, paradoxically, invisible among white, middle-class women.

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[5] Elayne Rapping addresses the charges of sensationalism and exploitation made against talk shows, including *Oprah*, when they became popular in the late 1980s and early 1990s. See Chapter One, "Oprah, Geraldo, and the Movie of the Week: Recovery-Talk Takes Over" in *The Culture of Recovery*.

Interestingly, several of *Oprah*'s guests express distress over the invisibility enabled by their whiteness, class, and gender conformity, which they describe simply as their "normal" appearances and "perfect outside[s]." The women repeatedly cite their normal appearances as troubling because such exteriors mask their addictions and prevent others from recognizing and (paradoxically) legitimating them as "drug addicts." Unlike their late-nineteenth- and early-twentieth-century predecessors, these women do not hide their addictions by keeping up "normal" appearances, that is, by performing their duties as wives and mothers. These women see themselves as victims of a normativity that conceals disturbing behaviours and/or signs of an illness not only from the outside world and family and friends, but also from themselves. The women speak of their drug addiction as something they struggle to identify because, as one guest says, "Those kinds of things wouldn't happen to someone like me."

The guests' common characterizations of their normal appearances as a problematic part of their addictions suggests that these women find little agency in their normativity. In fact, what these shows say to me is that women's (hetero)normative roles are quite uncomfortable, and that (hetero)normativity fails for these women, especially insofar as it renders their pain and problems invisible. I will return to this idea in my close reading of the *Oprah* shows. Such a critique of femininity, particularly as enabled by a discussion of women's drug addiction, could not be explicitly articulated in mainstream media such as *Oprah.* Nonetheless, *Oprah* plays with normativity in its construction of the female addict in ways that reveal the complexities of the relationship between women's prescribed roles and their drug use.

The women themselves represent their drug addictions as explicit and grave violations of their "proper" feminine roles, and such perceived violation of social and gender norms lends a sensational quality to the overall depiction of addicted women on *Oprah.* I would argue, however, that *Oprah*'s therapeutic intent and the language of therapeutics that Winfrey, the show's experts, and the guests use mitigate the sensationalism of the female addict because, within therapeutic culture, her experience is normalized, narrativized, and at least partially resolved.

Oprah's Therapeutic Imperative and The Drug Addict in Therapeutic Culture

In her article, "'That Shadowy Realm of the Interior': Oprah Winfrey and Hamlet's Glass," Eva Illouz describes talk shows generally and *The Oprah Winfrey Show* specifically as a "therapeutic genre" (112). As Illouz explains in her book, *Oprah Winfrey and the Glamour of Misery*, "using the basic therapeutic premise that our perceptions of reality shape that reality, the show preaches change through self-examination" (*Oprah* 133). Illouz argues that "like therapists, Oprah Winfrey solicits incessant reflexive self-observation from both her guests and her viewers by foregrounding emotions and identity" (*Oprah* 133). Most broadly, *Oprah* is premised upon an ethos of self-help that "calls upon the self to change itself in multiple areas of life in the name of an ideal of 'mental health'" (Illouz, *Oprah* 136). Of course, the central paradox of self-help is that it "deploys a vast apparatus to manage, [control], change, and improve the self" (Illouz, *Oprah* 124).

The Oprah Show functions as what Illouz calls a "vicarious support group" ("'That Shadowy'" 122). "Support groups," she explains, "participate in a pervasive, reigning therapeutic ethos which stipulates that the self can empower itself by talking about its predicaments and by exposing one's failings to the non-judgmental gaze of another" (Illouz, "'That Shadowy'" 123). This description corresponds to *Oprah*'s characteristic "empathic relation," which is "based on mutual self-disclosure and on an ethic of care" (Illouz, "'That Shadowy'" 122).

Thus, *Oprah* and the "symbolic recipes" the show offers in response to the social contradictions implicit in everyday life (Illouz, *Oprah* 61) exemplify, the therapeutic ethos that characterizes contemporary North American culture.[6] This distinguishing feature of the show is noteworthy because therapeutic culture also provides the dominant framework through which addiction is popularly conceptualized. The popular discourse of addiction and recovery and *Oprah*'s therapeutic discourse share many motifs: the importance of self-examination, the necessity of self-disclosure, the merit (and commodification) of autobiography, the centrality of emotion, the wounded and failed or "diminished" self (Furedi 106), and the imperative of expert intervention.

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[6] Critics began to identify a therapeutic ethos in American culture in the early 1980s. See, for example, T.J. Jackson Lears', "From Salvation to Self-realization: Advertising and the Therapeutic Roots of Consumer Culture, 1880 – 1930" in *The Culture of Consumption*. Among many other works, the following skillfully trace the rise of therapeutic culture and its implications: Szasz, *The Therapeutic State* (1984); Polsky, *The Rise of the Therapeutic State* (1991); Illouz, *Consuming the Romantic Utopia* (1997); Moskowitz, *In Therapy We Trust* (2001).

"Therapeutic culture," writes Furedi in the Introduction to *Therapy Culture*, "is often characterized as a retreat to the inner world of the self" (22). Indeed, "exploring and engaging with the inner-self has become an important constituent of contemporary identity" (Furedi 17). Therapeutic culture prescribes self-exploration and self-engagement not only for the purpose of constructing one's identity, but also for realizing self-fulfillment and happiness. Paradoxically, the orientation to the self – this emphasis on "looking inward" – has opened up the sphere of the private life to institutional management and control as well as to the public gaze.

Oprah is a perfect illustration of this phenomenon. Based on the notion that one's identity is a product of one's internal life, Winfrey invites her guests to reveal their private, emotional lives not only to an international audience, but also to the show's experts, who almost invariably interpret the guests' behaviours and emotions as individual, psychological problems that require further therapeutic attention. As in therapeutic culture generally, *Oprah*'s guests are defined (and often diagnosed) through their feelings. More accurately, they speak of a *self* that is defined by feelings. The state of the guests' emotions is often represented as the key determinant of their individual and collective behaviour (Furedi 25). Winfrey and her experts prompt guests to identify and examine their emotions as a means of self-transformation. Self-examination, in other words, is a requisite of the show's intended self-transformation. Furthermore, self-examination and its supposedly resultant self-transformation are represented as a means of empowerment.

Winfrey herself has said that her show aims to empower women (qtd. in Squire 98). Correspondingly, the show's calls for self-change are primarily directed at women, as is the ethos of self-help in general. As Janice Peck notes, women are "overrepresented as clients of the therapy industry as consumers of counseling, medication, self-help literature, and support groups" (Peck, "TV Talk Shows" 60). Women have enthusiastically embraced Winfrey's self-help ethos, explains Illouz,

> because it contains and synthesizes the two main contradictory cultural repertoires currently available to them: that of freedom and self-reliance, and that of intimacy and nurture. It affirms that, through self-observation and emotional control, the self can achieve a form of emotional independence that can in turn be conducive to stronger and better attachments. (*Oprah* 137)

Winfrey's self-help ethos, in other words, helps women negotiate the contradictory demands of femininity. Empowerment is not defined in terms of one's social position or role, however; it is defined, rather, in terms of the self's ability to manage emotions, or to appear to do so.

Change is similarly conceptualized; it is exclusively individually, rather than socially, directed and it revolves around the management of emotion. Moreover, as therapeutic culture dictates, and as Winfrey urges, change occurs through the act of telling, specifically autobiographical storytelling. More precisely, "change is performatively induced by the telling and showing of suffering" (Illouz, *Oprah* 129). Illouz is writing about *Oprah* here, but this statement aptly describes the broader cultural framework and formula of therapeutic change as well, where suffering and psychic pain define the self and function as "the key narrative device to make sense of the self" (Illouz, *Oprah* 118), and where self-disclosure or (auto)biographical telling are privileged ways to make sense of and transform that pain. As Winfrey's repeated commendations of her guests illustrate, self-disclosure is "an act of virtue in therapeutic culture" (Furedi 42) in part because it marks the initiation of self-transformation.

Equally significant, disclosure also "represents the point of departure in the act of seeking help" (Furedi 42); and help-seeking is also a virtuous act in therapeutic culture (Furedi 42). As Furedi reminds us, however, "help-seeking also constitutes the precondition for the management of people's emotions" (42). In other words, together with the motif of the wounded or suffering self, the privileging of self-disclosure as the key to self-transformation "enables the generation of a discourse and a dynamic of emotional 'empowerment' under the guidance and authority of experts and spiritual guides" (Illouz, *Oprah* 136). Self-disclosure and confession in the name of therapy, "offer a route to public acceptance and acclaim" (Furedi 42) at the same time as they invite and authorize therapeutic intervention.

Filtered through a therapeutic ethos, the popular discourse of addiction and recovery dictates a comparable orientation to and ordering of the self. Like *Oprah*'s therapeutic imperative, the popular discourse of addiction and recovery emphasizes the necessity of self-examination and calls for self-disclosure and autobiographical storytelling as the prerequisites of self-transformation and empowerment. This discursive trajectory also inevitably leads to the requirement of "expert," therapeutic intervention.

The self imagined by Winfrey under a therapeutic ethos, in fact, closely resembles contemporary conceptualizations of the drug addict's selfhood. The addict is a paradigmatic wounded and/or failed self. She makes sense of her addiction largely through the motif of psychic pain and a history of personal suffering. The understanding of addiction as constitutive of one's entire identity (as opposed to a behaviour among other behaviours) means that the addict is already oriented to the self in a way that therapeutic culture and Winfrey prescribe. That is, the drug addict has long been told that her problem resides somehow, somewhere in the supposed core of her being, even while she apparently suffers from a "disease." Even as it is theorized as self-effacement, addiction circumscribes the self. Furthermore, given that recovery from addiction is widely understood as an act of self-transformation that requires thorough and incessant self-observation and self-examination, as well as the constant management of emotions and self-disclosure via confessional, autobiographical practices, *Oprah*'s therapeutic imperative applies almost seamlessly to the drug addict.

Indeed, the therapeutic structure through which *Oprah* encourages individual change mirrors the rhetoric of and process of recovery. Recovery from addiction necessitates a complete revision of identity primarily because addiction is understood as totalizing in its effects on one's self.[7] This complete revision of identity as the project of recovery contains at least two central paradoxes, however. Most obviously, as I have previously noted, according to the Twelve Step discourse, *the addict is always an addict*, which means that, although she must alter her behaviour in order to reimagine herself as someone or something other than an *addict*, *addict* remains the focal point of this reimagining. Secondly, the new identity that recovery requires is often described as an essential, "true" self who was hidden by the addiction. In this way, recovery from addiction is understood as the recuperation, the recovery of the self rather than as the invention of a new identity. *Oprah* often conceptualizes self-change similarly; she encourages guests to recuperate or (re)discover a "true" self buried beneath pain and suffering while she offers ways to reinvent the self or construct a new identity (Wilson 4).

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[7] Recall Eve Sedgwick's Foucauldian account of the "invention" of the addict at the end of the nineteenth century: "what had been a question of acts," she writes, "crystallized into a question of identities. . . . The nineteenth-century [addict] became a personage, a past, a case history, and a childhood. . . . [His addiction] was

Oprah's therapeutic imperative and recovery alike require the addict (or the subject, more generally) to "work on and improve. . . the inner psychological core of the self" (Illouz, *Oprah* 135) rather than her moral make-up or actions. Of course, recovery mandates behavioural change, but such change is said to be achieved through work on the "inner self," which again primarily means learning how to recognize and manage emotions, as we saw also in Lydon's memoir. Recovery demands that the addict assess and narrativize the emotional impact of painful personal relationships as a way to understand her addiction in order to "move beyond it" and create a "healthy self." In much the same way that *Oprah*'s guests represent their emotions as the determinant of their behaviour and are encouraged to define a core self through their feelings, recovering addicts often

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everywhere present in him: at the root of all his actions because it was their insidious and indefinitely active principle" (parentheses in original; 130-31).

construct an etiology of their addiction based on negative emotions and a history of emotional injury that is devoid of social and political context.

Thus, the imperative of self-disclosure as the initiation of self-transformation that characterizes Winfrey's self-help ethos also characterizes recovery from addiction. Winfrey's use of autobiographical storytelling as therapeutic has a counterpart in Twelve-Step recovery programs where immediate confession is required and where the recurrent telling of one's life story is prescribed and ascribed the power to heal and enable conversion. *Oprah*, the Twelve-Step ethos, and the recovery movement in general prize self-disclosure and autobiographical storytelling as not only empowering and self-transformative, but also as tools to help others who are suffering. Addicted women on *Oprah* expect, first, that their self-disclosures, their acts of autobiographical storytelling, will bring about self-transformation, and, second, that they will help others who are suffering similar predicaments by publicly recounting their personal stories.

Methamphetamine-Addicted Women on *Oprah*

Twice in 2005 *Oprah* featured young, white, middle- to upper-class, suburban women who readily described themselves as addicted to crystal methamphetamine (meth). In this section, I read three of these women's stories of addiction to methamphetamine from two *Oprah* shows, "Will She Choose Life or Death? An Oprah Show Intervention" (13 May 2005) and the follow-up show, "The 17-year-old Meth Addict: Did She Quit?" (28 November 2005).

In May 2005, Oprah staged what she called her "first intervention on the show." The show focuses on Chantel, a suburban teenager addicted to methamphetamine. In keeping with Winfrey's intent to "'empower the self' and help others who are suffering" (Illouz, *Oprah* 78), she assures Chantel that she represents "the possibility of what can be" and that she "will use this to help other girls and help people." After tearful pleas from her mother and sister, and after Winfrey's exhortations, Chantel agrees to leave with a counselor from the Caron Foundation, who, we are told, will escort Chantel by car and then by airplane to an in-patient treatment center in Pennsylvania.

Integrating clips from an episode of A&E's *Intervention*,[8] the second half of *Oprah*'s intervention show profiles Sara, "a young suburban Minnesota mother who also got hooked on" methamphetamine. After the *Intervention* clips, Sara appears on stage and Winfrey establishes that she has "been clean" for four months.

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[8] The "Oprah Show Intervention" cites A&E's "reality/documentary" (www.aetv.com/intervention) show, *Intervention*, which, as the show's title indicates, documents interventions, the dramatic scenes in which family and friends confront the (usually very hostile) addict with the intention of convincing her that she needs immediate professional help. At the end of the show, Oprah announces the date and time that *Intervention* airs. Oprah's intervention program and its follow-up, "The 17-year-old Meth Addict: Did she quit?" also incorporate brief clips from other television shows, such as a TLC program called "Moms on Meth." Amy Hart, the women featured in the photo on the lead page of the *Glamour* article, makes a very brief appearance in one of these clips at the beginning of the "Did she quit?" show. Such tie-ins or cross-promotions are a common feature of *Oprah*.

In her book, *Oprah, Celebrity and Formations of the Self*, Sherryl Wilson discusses "the relation between the advertising industry and ideas of the therapeutic" (60) as they get played out on *Oprah*. She suggests that personal narratives are sutured into a process of consumption via the show's self-reflexivity around commercial breaks, for example (60). The use of excerpts from other shows operates similarly; this technique links individual's stories with the commercial enterprise of marketing other television shows. For further discussion of the relation between advertising and therapeutic culture on *Oprah*, see Wilson, especially Chapter 2: "Anxiety and Agency: Oprah and Constructions of the Self." For a discussion of the intertwined history of the discourses of the advertising industry and therapeutics, see T.J. Lears' "From Salvation to Self-Realization: Advertising and the Therapeutic Roots of Consumer Culture, 1880 – 1930."

Prompted by Winfrey, Sara proceeds to identify herself as an addict and to describe her recovery process, both of which revolve significantly around her failure as a mother.

Between the two stories of these young, white, suburban addicted women, Debra Jay, "addiction specialist and . . . former counselor at the world-renowned Hazelden Treatment Center," provides an explanation of methamphetamine addiction that intertwines neurobiological, psychological, and moral discourses. Jay's role on the intervention show is consistent with *Oprah*'s therapeutic imperative and the discourse of drug addiction under therapeutic culture, both of which not only regard "expert" intervention as a necessity, but also rely on social figures defined as authoritative ("experts") to interpret behaviours and offer solutions to predicaments.

The women's stories of drug addiction incorporate and reflect institutional, "expert" voices, including Jay's. "Therapeutic stories," writes Illouz, "come 'attached,' so to speak, to their own set of experts, who contribute to institutionalizing this narrative discourse by providing causal frames, etiology, and plans of action" (*Oprah* 89). Jay's role as an expert, on both the intervention show and its follow-up,[9] is precisely that. Her discourse gets reinforced by Winfrey, taken up by the guests and incorporated into their life stories.

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[9] Jay is *Oprah*'s resident "addiction specialist." Since 2003, she has appeared on seven shows that deal with women's addiction, including prescription drug addiction, illicit drug addiction, and alcoholism: "Suburban Moms Addicted to Drugs" (19 Nov. 2003), "Inside Detox" (28 Jan. 2004), "Moms Addicted to Drugs" (7 April 2004), "Moms Who Drink Too Much" (19 April 2004), "Can This Suburban Mom Stop Drinking?" (7 Oct. 2004), the "Intervention Show" and its follow-up, "Did She Quit?"

The first segment of the follow-up show answers the title question, "The 17-year-old Meth Addict: Did She Quit?", affirmatively. After recapping Chantel's experiences as a meth addict through clips of the May show, Winfrey briefly interviews Chantel about the difficulties of life as a "recovering" addict.[10] Winfrey's next guest is Michele Cook, another "suburban mom" addicted to methamphetamine. Cook's addiction is remarkable not only because she was, in Winfrey's words, "living what is for many the American Dream," but also because it came about during an extramarital affair. An explicit violation of her roles as a "proper" wife and mother, Cook's affair reinforces longstanding associations between female sexuality – more specifically, promiscuity or otherwise "improper" and excessive female sexuality – and drug addiction. The show ends with the brief but lurid story of, in Winfrey's words, "how meth sent one successful [gay] man into a sexual underworld" (17).[11] After this segment, Winfrey concludes with a general remark about the show's educational intent: "Now you know," she says, "how devastating a drug it is – crystal meth."

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[10] This show also promptly proceeds to reveal the fulfillment of Winfrey's prophetic declaration, from six months earlier, that Chantel's experience will be helpful to "other girls;" Winfrey recounts the experience of a mother who recognized Megan, her seventeen-year-old daughter, in Chantel. Realizing that Megan's disturbing behaviour meant that she was using meth, Megan's mother and sister forced her to watch Chantel's story. Megan was likewise struck: "My eyes were wide open," she recalls. Then, as Winfrey tells the story, "When [the show] was over, Megan finally admitted she had a drug problem and agreed to go to rehab where she came face to face with Chantel. . . .The two girls instantly bonded." The girls exchange enthusiastic hugs on stage, and, having noted the heroic utility of the figure of the young, white, suburban drug addicted woman and confirmed *Oprah*'s role as a beacon of self-help, the show quickly moves on.

[11] In the final and shortest segment of "Did she quit?" Winfrey interviews Jay Dagenhart, a former methamphetamine addict and gay man who is campaigning to raise awareness of methamphetamine addiction among gay men. Winfrey's introduction to this segment explicitly links what has long been conceptualized as "deviant" sexuality with drug use: "Experts claim that crystal meth can dramatically increase reckless sexual behaviour and has led to rising rates of HIV in gay and bisexual men. Jay Dagenhart says that those experts are right." Dagenhart openly

Chantel: "The All-American Girl" Meth Addict

Before we meet Chantel, the teenaged subject of *Oprah*'s intervention, Winfrey provides an overview of "the crystal meth epidemic" through a series of

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discusses sexual behaviour like "bare backing" ("anal sex without condoms") as a consequence of the methamphetamine high. He confesses to "unprotected sex with as many as 25 men in one night" and "bug chasing" – looking for men who are experiencing wasting to have sex with in hopes of becoming HIV positive. Dagenhart describes this behaviour as the direct result of methamphetamine use: gay men are "barebacking" and "bug chasing," he says, "because the drug just twists your mind so much." He also claims a kind of ownership of addiction as a sequel "disease" to HIV: "My gay brothers are suffering. You know, we have HIV. AIDS is our disease and now we have the disease of addiction."

Although beyond the scope of this project, Dagenhart's segment is clearly dense enough to fill a chapter. What I want to point out here is that *Oprah* once again draws on a historically persistent link between illicit drug use and "abnormal" and "unhealthy" sexual practices. Illicit drug use both leads to and is a consequence of troubling sexuality. Furthermore, both drug addiction and "unconventional" sexual behaviour result in contagion, here and historically. For further discussion on the intertwining discourses of sexuality, sexually transmitted diseases, and drug addiction, see Acker, *Creating the American Junkie.*

Dagenhart's story may seem like an odd addendum to stories of white, suburban women addicted to methamphetamine. Yet, we will recall that Cook's addiction narrative also begins with "inappropriate" sexual behaviour. Drug addiction has long figured as a kind of punishment for women who violate prescribed (hetero)sexual practices. Although no one in *Oprah*'s audience would (be able to) explicitly claim that drug addiction is an appropriate consequence or punishment for Dagenhart's homosexuality, there is an unsettling undertone in this segment that hints at this kind of judgment.

Dagenhart's homosexuality also feminizes him, which makes his story seem more fitting alongside white, suburban female addicts' stories. He is stereotypically effeminate. And such femininization renders him, like the previous female guests, "naturally" pathological and susceptible to drug addiction. For further discussion about the relationship between feminized gay men and illicit drug use, see Mara Kiere's "Dope Fiends and Degenerates: The Gendering of Addiction in the Early Twentieth Century." Eve Sedgwick also examines the relationship between drug addiction and what she calls "homo/heterosexual problematic" (173) in *Epistemology of the Closet.*

clips: Sheriff Rick Dart of Granite Falls, Washington, Chantel's hometown, proclaims, "I've been in law enforcement 32 years and methamphetamine is the worst drug I've ever seen;" two unidentified teen girls in a suburban setting tell the camera matter-of-factly, "Probably everyone you meet has at least tried it. I can say I could call someone right now and probably find it;" a young woman's burnt face flashes on the screen as Winfrey explains how "this 15-year-old skipped class to get high on meth and was disfigured when the meth lab she was in exploded." Neatly rehearsing conventional anti-drug rhetoric, Winfrey declares, "[crystal meth] is cheap, it's instantly addictive, often deadly and it's probably already in your neighborhood. The crystal meth epidemic is spreading like wildfire in cities and suburbs across America." Then she introduces the attractive, blonde, casually-dressed teenager sitting solemnly across from her: "Now this is Chantel. Chantel lives in Granite Falls, Washington. Her mother is a teacher's assistant and her dad sells life insurance. And 17-year-old Chantel is addicted to crystal meth." Chantel's addiction is set up with alarming rhetoric about her "drug of choice." Rather than being unexpected or anomalous, Chantel is cited as evidence of "the crystal meth epidemic."

The significance of her normativity, as Winfrey establishes it in part through her brief description of Chantel's parents, once again reveals one of the central paradoxes of the discourse of women's drug addiction. On the one hand, Chantel's middle-class, heteronormative family background supports the notion that, as Winfrey says, "everyone . . . [is] caught in [meth's] deadly grip." On the other hand, Chantel's drug use and addiction violate social norms, which likewise renders her addiction worthy of public attention. The unspoken implication here, however, is that this normativity has failed Chantel. Her drug addiction implicitly signals the failure of her parents' heteronormativity and her inherited middle-class privilege.

Winfrey's repeated references to Chantel as the "all-American girl" operate similarly. This label establishes and emphasizes Chantel's normative femininity, but what this femininity encompasses is taken for granted. Only her physical appearance readily connotes the "all-American girl" – a fact of which Winfrey seems conscious. Contemplating how unforeseen Chantel's addiction must have been to her parents, Winfrey remarks, "'cause you look like the all-American girl. Correct? This could be – this is anybody's daughter and everybody's daughter." Winfrey's comments suggest that Chantel's addiction violates dominant norms of femininity; she may "look like" the "all-American girl," but the fact of her addiction precludes femininity. At the same time, however, the show depends on Chantel's continued embodiment of femininity as the "all-American girl." The dominant discourse of women's drug addiction relies on this paradox. More accurately, it performs this paradox over and over: white, middle-class women necessarily violate social norms and gender roles when they take and become addicted to illicit drugs, but their addiction also reinforces stereotypes of women as more biologically vulnerable to such "psychological problems" or "mental illnesses."

After Winfrey establishes that Chantel has been caught in an "endless cycle of bingeing and crashing" for the past year and a half, she asks Chantel, "And what got you started?" Chantel responds, "Friends that I hung out with, the crowd and at my – in my town and stuff. It was just – *there was nothing to do.* There's nothing to do in the town besides party and do drugs" (emphasis mine). That Chantel locates the origins of her drug addiction in the absence of stimulating activities is noteworthy. Throughout the latter half of the nineteenth century, social commentators often cited boredom as one of the main reasons for drug use among upper-class women (Kandall 16). Women's boredom was a mark of their class privilege, like it is in Chantel's case. The boredom that led nineteenth-century upper-class women and Chantel alike to use drugs can be linked to the social oppression of women, although it rarely is. Even within the socioeconomic privileges of suburban America, the roles afforded to Chantel as an "all-American girl" are uninspiring to her.

On the follow-up show "Did She Quit?' Chantel offers a revised narrative of causation. After 122 days in treatment, Chantel sees the origins of her addiction in the suppression of her feelings: "I've always had drugs to cover up my feelings," she remarks. This (albeit abbreviated) causal narrative is typical of Winfrey's therapeutic ethos and the popular discourse of addiction and recovery, both of which locate an array of problematic behaviours, including so-called compulsive behaviours, in overwhelming or excessive emotional pain and/or its suppression. Chantel's revised narrative erases the link she so tenuously made in the previous show between her drug use and her socioeconomic status. Instead of working to understand how the expectations of her suburban life, her heteronormative family, and her "all-American girl" appearance might limit her and affect her desire to take drugs and participate in a culture of drug use, recovery directs Chantel to her invariably troubling and troubled "inner self." "Feelings" stand in for an array of experiences that need not be examined as consequences of anything other than internal processes and reactions.

The segment goes on to document Chantel at home, six weeks out of treatment, as she unleashes her emotions in explosive confrontations with her mother. Throughout the videotaped excerpts, Chantel's descriptions of her drug addiction and of herself as an addict faithfully reproduce the rhetoric of recovery. During one fight with her mother, Chantel's voice shifts from typical expletive teenaged outrage to a formal, comparatively detached disclaimer: "No drug addict just out of rehab is going to be perfect," she informs her mother. In another instance, Chantel explains the rage she directs at her mother as the return of her "addict behavior": "I was mad and angry and I thought my addict behavior is back and I was just like blaming her for everything." Chantel demonstrates that she has learned to be more "self-aware" in treatment. She is able to identify emotions and recognize that her behaviour affects those around her. As much as recovery has directed Chantel to understand her addiction through attention to her internal processes, however, these inner experiences of addiction are paradoxically externalized as "addict behavior." An entity in and of itself, "addict behavior" reduces Chantel's agency over her own thoughts and behaviours.

Beyond this reiteration of recovery rhetoric, which vaguely situates the causes of Chantel's addiction in an inability to express or otherwise "deal with" her emotions, neither Chantel nor her mother Penni, who accompanies Chantel on the shows, offers clear reasons for Chantel's addiction. Nor are they required to. After all, Chantel's addiction is contextualized by the rhetoric of methamphetamine addiction as a "national crisis" and a "deadly epidemic." The apparent fact of the drug's ubiquity accounts for how it came into the lives of young, white, middle-class, suburban women like Chantel. Likewise, methamphetamine's supposedly instant addictiveness and its overwhelming potency accounts for the addiction itself. It is only after treatment that Chantel and the other methamphetamine-addicted women develop causal narratives. More precisely, it is only after treatment that individual, personal reasons for drug dependence become relevant. While the rhetoric of methamphetamine use as a "national crisis" smacks of propagandistic scapegoatism, at least it points towards a cultural context for understanding addiction, however ambiguous that context may be. The causal narratives that emerge after treatment are invariably individually-focused.

Debra Jay: Addiction Expert

Experts also intervene on *Oprah* to provide their own etiologies of methamphetamine addiction. Persuaded by her mother and sister's tearful pleas, Chantel agrees to get into a waiting car that will take her to the airport and onto a treatment facility. When she leaves the stage, Winfrey previews "expert" accounts of methamphetamine: "Coming up. . . Experts say it's the devil drug. How crystal meth eats away at your brain." After the break, she introduces "addiction specialist," Debra Jay. Jay begins, "There are almost no words to describe this drug" – the implication being that the "horror," as she says, of methamphetamine is so extreme that it is unrepresentable. Ironically, Jay then presents a series of photographs that show, in her words, "the tragic toll that crystal meth can take on a person's physical appearance." Images of the brain quickly supercede portraits, and magnetically resonant holes replace infected facial sores as the mark of methamphetamine use. Jay explains that methamphetamine "literally atrophies, shrivels and shrinks the brain. . . . Methamphetamine brain is much like Alzheimer's brain, and in Alzheimer's patients, what happens is it programs the brain to – the brain cells start destroying themselves." Jay refers to Chantel's behaviour as evidence of this neurobiological transformation:

> Remember on the video with Chantel how she was talking about her drug addiction, just like it was nothing. . . . You lose the ability to learn from past mistakes or to care about anything. And it's not because she's bad; it's because her brain no longer works. And this can be permanent. That's why it was so important to get her into treatment.

Winfrey interjects, "Why do you say meth addicts are like sociopaths, Debra?" Jay responds, "Their conscience is completely suppressed. You know, sociopaths feel no sense of right or wrong no matter what they do. And this drug makes a meth addict just like a sociopath." Jay's conceptualization of methamphetamine addiction is rich with discursive slippages: neurobiology slides into psychology and the two converge in morality.

Reflecting the growing prominence and authority of neurobiology in the conceptualization and representation of addiction, Jay's explanation rests on neurophysiological changes. In fact, Jay uses neurophysiological changes to justify coerced treatment. The possibility of permanent brain changes that negatively affect a woman's attitudes and behaviours is, in Jay's schema, reason enough for compulsory treatment. Although neurobiological concepts of addiction are couched in the rhetoric of medical innovation, Jay's description of methamphetamine's effects on the brain is reminiscent of The Partnership for a

Drug-free America campaign of the late 1980s, which compared a sizzling egg to "your brain on drugs."[12]

Neurobiology gets intertwined with other older, stigmatizing concepts of addiction here as well. Jay's explanation is reminiscent of early-to-mid-twentieth-century concepts of the drug addict as socio- and psychopathic. Although popularized during the 1920s by psychiatrist and US Public Health researcher Lawrence Kolb, the notion that drug addicts inherently lack a conscience, a sense of right or wrong (Acker, "Stigma" 201), remains centrally associated with certain addicts, namely poor people of colour. For others, like Chantel, neurobiological narratives of addiction seem to explain away typically sociopathic behaviour.

We need to ask, however, whether Chantel actually escapes the stigma of socio- and psychopathology. What is the difference between being a sociopath and being "just like" a sociopath for these white, middle-class addicted women? The main difference is in the assignment of blame; these "just like . . . sociopath[ic]" women are not expressly blamed for their addictions and arguably bear less stigma as addicts because, according to Jay and the dominant discourse she represents, they only *resemble* sociopaths, and this resemblance is the fault of the drug. This likeness nonetheless justifies institutional intervention and medical treatment.

Jay's explanation of methamphetamine's effects leaves the women without agency. The expert discourse here blends religious and moral descriptions with lay versions of scientific, neurobiological concepts, all of which depict the women as remarkably feeble in the face of methamphetamine. Recall Winfrey's opening paraphrase of expert discourses on methamphetamine: "it's the devil's drug . . . [that] eats away at your brain." An echo of the earliest anti-drug campaigns, which were part of the Progressive Era reform movement of the 1910s and '20s, and which were notably led by upper-middle-class Anglo-American Protestants (Acker, *Creating* 2), the phrase, "the devil's drug" should seem anachronistic. But, in contemporary America, such figurative, religious language has an important resonance in mainstream representation of drug use and addiction; it reminds us that women's drug addiction is still regarded as a moral issue. According to Jay's "expert" explanation of methamphetamine addiction, addicted women are morally, psychologically, and physically vulnerable.

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[12] To view the infamous fried egg of the 1987 "This is your brain on drugs" public service announcement, go to www.drugfree.org/Portal/About/NewsReleases/Fried_Egg_Message.

Sara: "Suburban Mother on Meth"

The segment following this expert account profiles Sara, a 24-year-old "suburban Minnesota mother." Sara's story illustrates how powerful moral ideas about drug addiction are, especially for white, middle-class women, who have historically culturally embodied "goodness." While Jay's morally inflected rhetoric seems to absolve culpability for their addictions, it nonetheless evokes connotations of moral weakness and failure. Repeatedly citing her personal history of normative femininity as evidence of both her goodness and psychological stability, and as evidence of her failure, Sara's story simultaneously refutes claims of moral weakness and catalogues her transgressions as a female addict.

Sara's story opens with clips from A&E's *Intervention*. A visibly distraught Sara introduces herself using the conventional confessional Twelve-Step salutation: "My name is Sara. . . .I'm a meth addict." Through voiceover, she offers an autobiographical sketch of her life as the audience watches home video of her as a happy toddler and young girl:

> This wasn't supposed to happen to me. . . . I wasn't supposed to be this person.
>
> My childhood was more than most kids have. I was raised with morals and values. I couldn't have asked for better parents. My mom has been a stay-at-home mom since I've been [sic] about three years old. My dad has always been a hard-working man and I've always wanted to go to school for law enforcement. I was first runner-up in the Miss Minneapolis beauty pageant. I had a fairy tale wedding. I had a beautiful little girl.

Sara's story is a delineation of normative femininity. Raised by a "proper" "stay-at-home mom," appropriately concerned with her physical appearance, able to achieve society's standards of female beauty, meet the heteronormative imperative of marriage and within it realize the typically feminine "fairy tale," and fulfill her "proper" role as a mother, before her drug use and addiction Sara exemplified normative femininity. Again, there is no suggestion that the pursuit of normativity or adherence to norms, which Sara's autobiographical catalogue of normativity depicts, might cause the kind of anxiety and intense dissatisfaction that could be (at least temporarily) mitigated with drugs. In the narrative that Sara (with Winfrey and *Intervention*) constructs, crystal methamphetamine systematically destroys each of her "proper" roles and marks of femininity: "I'm not a good mom. I'm not a good daughter. I'm nothing. I have nobody," says Sara. Winfrey adds, "In three years, Sara has lost her car, her job, her house, and her marriage to crystal meth. She also lost custody of her daughter, Madison." Sara also describes her facial sores, emaciated body, thinning hair, and rotting teeth, which signal not only the loss of her good looks, but the loss of an appropriately feminine concern for her physical appearance as well. Sara denounces herself for all of these losses, but she expresses the most shame over her failure as a mother.

Her recollections of being an addict begin with a memory of her two-year-old daughter, sitting on the living room floor, looking up at her, and saying, "Mommy, you need to lay off the drugs." In an excerpt from A&E's *Intervention* Sara does not just mourn her daughter, she constructs the negation of her responsibility as a mother as the ideal impetus for not using drugs: "I thought losing my daughter over two years ago would be enough for me to stop using and we're going on almost three years now and I'm still using. . . . I'm missing out on all those things that two-year-olds and three-year-olds go through." Motherhood signals Sara's worth at the same time as it measures the gravity and severity of her transgression as a female addict. Yet, her remorse over her failure as a mother allows for the possibility that she is culturally redeemable.

Later in the interview, Winfrey asks Sara about her experiences "coming off of the drug": "I understand you felt every feeling that you had numbed for years?" This inquiry, typical of *Oprah*'s therapeutic imperative, Winfrey's role as a kind of therapist, and the discourse of drug addiction and recovery, leads Sara back to her failure as a mother. "Yes," she replies, ". . . the counselors really nail[ed] me with questions about Madison and instead of running and going to get high, I had to deal with the fact that I had just lost my daughter, that my ex-husband has got my little girl." Winfrey steps in, "But . . . doesn't he deserve to have her? You weren't – you were not. . ." (ellipsis in original). Sara concedes, "Yes. . . I was in no state of mind to take care of a two-year-old at the time." Winfrey then half-queries, "So you were doing drugs the whole time you were raising her," to which Sara tearfully confesses,

> I couldn't even begin right now to write in her baby book. . . . I don't remember when her first step was. I don't remember what her first word was. . . . I haven't been to her doctor's appointment in I don't know how long. I don't know what shots she should have. I don't know the things that parents do.

This exchange encapsulates a broader cultural imperative for addicted women who are mothers to negotiate their addiction and their cultural redemption through the trope of motherhood. Winfrey's hesitant, near rebuke ("You weren't. . .") suggests that Sara must do more than express her pain and regret over losing custody of her daughter; she must acknowledge that she was "not fit" to be a mother to her child. The cultural currency of such an admission is contradictory: it admits the possibility that not parenting was the best parenting, but it does not allow for Sara to escape the guilt of failing to be a "proper" mother.

After Sara's catalogue of her transgressions as a mother, Winfrey directs the conversation to the question of relapsing. Sara explains that she refuses the call of addiction and avoids relapse by going to meetings, going to church, and talking to her parents "instead of isolating": "I'm letting them know what's making me upset, what's making me angry so we can work through it. Because," she adds, "I remember a lot of the things that I would go get high over." Not surprisingly, the management of emotions is central to Sara not using drugs. Moreover, her new emotional consciousness has helped Sara rebuild her relationship with her parents, which, as a mark of recovery, earns her some credibility. It demonstrates that she is, in clinical psychology terms, "fostering relational responsibility" (Krestan and Bepko 62).

Winfrey then recalls Sara's initially violent response to her (televised) intervention, which brings Winfrey to an important question about the imperative of external, institutional help. She asks Sara, "Is this something you could have done on your own, gotten yourself off this drug?" Sara replies, "No, not – never in a million years would I have been able to have done this." Sara's response (and Winfrey's question) reproduces one of the fundamental "truths" of what we think we know about the addict: that she cannot "overcome" her addiction without professional, "expert" intervention. As Sedgwick reminds us, since the taxonomic reframing of the drug user as an addict at the turn of the nineteenth century, the addict has been "the proper *object* of compulsory institutional disciplines, legal and medical . . . that presume to know her better than she can know herself" (131). The imperative of expert intervention, of course, is also consistent with Winfrey's therapeutic ethos and therapeutic culture more generally, where "any problem can function as the departure point for a narrative in which the self becomes a (specific) problem to itself, and is the pretext for mobilizing an 'expert' who specializes in one particular form of dysfunction" (Illouz, *Oprah* 89).

While I am suspicious of the imperative of expert intervention in the discourse of drug addiction as a mechanism by which the addict is inexorably institutionalized, or more specifically, in the case of the white, middle-class female addict, by which she is made a perpetual object of the medical gaze, expert intervention addresses some of the problems identified in theories of addiction. If, for example, we accept the notion that addiction is an adaptive behaviour, a relational structure that stands in for broken social ties and institutions, then expert intervention ostensibly offers a path to social reintegration. Therapeutic intervention, in the case of the drug addict, restructures the relation of dependency: it attempts to move the addict away from a dependence on drugs to a wider network of (culturally sanctioned) social institutions. As Sara adds, "it helped, too, to get me out of, you know, . . . away from everybody that I was using with."

To end the segment, Winfrey returns to the A&E pieces. She reflects on how unforeseeable Sara's addiction is in these images of her as a little girl: "nobody when you're that age thinks you're going to grow up to be a meth addict." Revisiting her childhood of normative femininity, Sara concurs, "that's just it. . . I mean I was horseback riding, you know, beauty pageants. I mean, I had – doing everything that teen-age girls do, and then it just – it caught me just like that, and it took me just like that." Drug addiction interrupts Sara's life story; it takes her out of a narrative of normativity, but it also keeps her addiction story circulating in relation to normativity.

That Sara's story is framed by descriptions of her very "normal" childhood and adolescence also unsettles dominant, therapeutic narratives of addiction as rooted in a history of emotional injury or personal suffering. There is, in other words, no trauma narrative to mark the origin of Sara's addiction. Her "self" is not the paradigmatic wounded addict self, although, because of the addiction, it is now a "failed self." Certainly, psychic pain is central to Sara's addiction narrative; the addiction itself represents a kind of trauma or at least precipitates emotional pain, especially as her story revolves around her failures as a mother. On the one hand, then, Sara's history of normality and normativity, which is implicitly equated with a lack of emotional pain, troubles dominant narratives of addiction's etiology. On the other hand, this same history reinforces the rhetoric of methamphetamine use and addiction; it is precisely because of this history of normality that Sara's story, like Chantel's, reads as evidence of the "deadly epidemic" of methamphetamine.

Michele: "Suburban Mom Fighting Addiction to Meth"

Michele Cook is the last addicted woman to appear on the follow-up show, "The 17-year-old Meth Addict: Did She Quit?" Excerpts of a TLC program called "Moms on Meth" immediately precede Michele's segment. A series of women describe the same offense with slight variations: "all of these women did drugs with their children in the house." One woman confesses, "I used every day and I used drugs my whole pregnancy." Another recounts driving her children to the "middle of the desert," demanding they get out of the car, and driving away. "I went back," she continues, "and got them back into the car and they were just standing there bawling." She finishes her story quietly: "There's nothing I can do to take that back." Another woman offers a nominal explanation for all of this troubling behaviour as she describes her own experience: "Emotionally, you cannot connect with your child," she says.

Drug-using mothers play stunningly demonized roles in these excerpts. These pieces of stories catalogue what are culturally deemed the most horrific and sensational offenses a mother can commit. Drug use during pregnancy, which presumes neonatal addiction and life-long illness, abandonment, and emotional neglect, signals a loss of "maternal instinct." Addiction is so powerful, so the story goes, that it not only leaves women unable to fulfill their "natural" maternal role, but also transforms them into "victimizers" (Campbell 170).

At the same time as these pieces of stories are meant to shock viewers into recognizing methamphetamine as "the most dangerous drug in America," they are also meant to represent women's "everyday" experiences. After all, methamphetamine use is "the deadly epidemic that's infiltrating our neighborhoods, our schools in every city in every state in America." These addicted women, by virtue of appearing on *Oprah* and by virtue of their whiteness, middle-class status, and femininity, are meant to represent "mainstream America." Their stories are presumed to resonate with viewers because they are familiar and they are presumed to offer hope and help in their familiarity. Thus, addicted women and their stories upset any easy normal/deviant dichotomy. Addicted women on *Oprah* simultaneously display attributes of "normality" and normativity as well as "deviance" and marginality, as the show's guests often do (Illouz, *Oprah* 68).

Against this paradoxical paradigm, Winfrey introduces Michele: "Three years ago, Michele Cook was living what is for many the American Dream." In a videotaped excerpt, Cook also begins her story by painting herself in "the American Dream":

> I was your typical suburban mom. I had a great husband. I had a great child. We lived in a very established neighborhood. And my husband had a wonderful career at the time. I used to coach my son's soccer. I was PTA president. I was very involved in the church. I was a Bible study teacher.

Winfrey and Cook's voices alternate to construct a biographical story of the origins of Cook's addiction to methamphetamine:

Winfrey: But after 14 years of marriage, her relationship with her husband started to change.

Ms. Cook: There wasn't a lot of intimacy there because he traveled quite a bit. We were more best friends than anything.

Winfrey: Then Michele met someone else.

Ms. Cook: That person was fulfilling my needs at that time and it was a temporary solution.

Winfrey: Her new boyfriend introduced her to crystal meth. She was 36 years old and had never tried any illegal drugs in her life.

Ms. Cook: I had no idea what meth was. I'd never seen it, never used it. I thought, 'Oh, I'll do this recreationally whenever someone has it,' but I was instantly hooked.

Winfrey: Soon the meth began consuming her.

Michele's story, like Sara's, starts with her exemplification of normativity and normative femininity. In fact, Michele goes beyond "normal;" she establishes herself as virtuous and moral.

Unlike Sara's story of normative femininity, which seems to me to hint at the fervent pursuit of normativity as a causal narrative of her addiction, Michele's story locates the origin of her addiction in a transgression of normative femininity and the moral code she implicitly lays out in her introductory remarks. Her extramarital affair marks the beginning of her addiction. Heterosexual women's stories of their initiation into "drug culture," or their stories of initial drug experiences frequently revolve around a new, often culturally forbidden, male romantic partner. Instead of demonizing the man as a "victimizer," however, this scenario stigmatizes the woman as morally weak and/or hypersexual. Figuratively, Michele's drug addiction reads as punishment for her "inappropriate" sexual behaviour.

I am tempted to criticize my interpretation here as archaic. Surely, women's extramarital affairs are no longer sensational offenses for which they are castigated and outcast, are they? Michele is not exactly the Victorian "fallen woman" – ostracized and irredeemable until death. And *Oprah*'s audience is likely unsurprised by Michele's infidelity – troubled relationships being common talk show fare. Yet, in the narrative Michele and Winfrey construct, the affair leads directly and immediately to methamphetamine addiction. Sexuality performed outside the "proper" domestic sphere and confines of her marriage is inextricably linked to Michele's drug addiction.

Perhaps this relation is more effectively interpreted, however, as illuminating another contradiction of femininity. Michele's brief justification of her infidelity – "there wasn't a lot of intimacy [in the marriage]" – and her description of the affair – "that person was fulfilling my needs" – suggests that she understands that, as a conventionally attractive, suburban, white, heterosexual woman, she is entitled, or at least culturally permitted to seek sexual intimacy and pleasure. At one point during the interview, Winfrey asks her what convinced her to do methamphetamine. She responds, "[I] got caught up in the fun." Aside from a brief remark that Chantel makes about methamphetamine making her feel happy, this is the only reference to the pleasure the women experience from the drug. Thus, at the same time as white, middle-class women are encouraged to pursue pleasure and pleasurable experiences that have been historically prohibited or for which women have been stigmatized, they are also often judged or culturally punished for doing so. Michele's affair, in the context of the story of her addiction, illustrates this contradictory trait of normative femininity: a woman can pursue corporeal pleasure only if she does not transgress the heteronormative moral code.

Michele's story also contains an odd twist that revolves around her son. In what *The Oprah Show* website entitles "A Grim 'Lightbulb' Moment," Michele recounts her ex-husband, Mike's discovery of a discarded lightbulb. Michele's first-hand knowledge "that meth can be smoked by using a lightbulb" leads her to a "grim" realization: "When my ex-husband showed it to me and I saw the residue down at the bottom and I lit it and tasted it and knew what it was, that's when I knew my son had a problem." Met with vehement denial, Michele and Mike make Chandler, their 13-year-old son, take a home drug test, which comes back positive. Winfrey narrates, "Michele and Mike immediately took their son to rehab. On the ride home, all Michele could think about was her next fix." Michele recalls the scene, "[A]s soon as I pulled out of the parking lot and got back on the street, I pulled over on the side of the road and took a puff. I felt guilty. How can I say, 'Chandler, this is what you need to do,' when I've gotten high?"

A strange intergenerational transmission of addiction is depicted here. Although no one infers that Michele introduced Chandler to methamphetamine, or that drug use was something Chandler learned by watching his mother, the implication is that drug addiction is somehow passed on here from mother to son. This scenario evokes several theories of addiction, although it does not direct the conversation to them. First, it calls to mind the notion that addiction is a genetic condition that can be inherited.[13] According to this popular biological theory, Michele's addiction automatically renders Chandler genetically susceptible to addiction. Chandler's drug use also evokes social environment theories of addiction, which would see Michele's addiction as part of a "dysfunctional" home life that would contribute to her son's drug use. Her addiction, and hence her failure as a mother, in other words, would appear to lead to Chandler's need for the effects of a stimulus (West). Regardless of how the audience understands addiction, however, this scenario of intergenerational transmission incriminates Michele, or we would expect that it would incriminate and stigmatize her as a victimizer, like the mothers in the TLC clips.

Yet, such incrimination does not become part of Michele's public auto/biography. Michele uses her son's drug use not to berate herself further or to theorize addiction, but as the impetus for her own recovery. And Winfrey, for the most part, accepts this narrative. She only asks, "Didn't you think you were a hypocrite?" Michele responds, "Yes, I did, but there are no emotions when you do this drug. Every single bit of emotion is taken away. You don't care about anyone but you and you don't think about those things. I mean, you're just – your emotions are completely gone." Given the centrality of emotion within *Oprah*'s therapeutic imperative for understanding and transforming one's self and one's life, Michele's description of the complete absence of emotions as a consequence and/or symptom of methamphetamine addiction is another indicator of the gravity of her problem. As a symptom of addiction, the loss of emotions reinforces necessity of therapeutic intervention that already prescribes "getting in touch with one's feelings."

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[13] Regular *Oprah* viewers would probably be familiar with this biological theory given its centrality to the conceptualization of women's other addictions on previous shows. On a 2003 show entitled "Suburban Moms Addicted to Drugs," which profiles white, middle-class women addicted to prescription drugs, Debra Jay emphatically describes addiction as "a genetically based disease." "It's a settled science," she proclaims. "It is the most complex genetic-based disease . . . of any chronic disease." Women's alcoholism is likewise conceptualized as a genetic disease on a 2004 show, "Can This Suburban Mom Stop Drinking?"(see http://www.oprah.com/tows/pastshows/200410/tows_past_20041007.jhtml). The disease concept and other biologically-based theories are not discussed on the methamphetamine shows, which indicates a significant difference between the discourses of women's illicit and licit drug use. "Settled science" is not used to describe and account for women's illicit drug use. White, middle-class women who use illicit drugs are culturally required to take more blame for their addictions than women who are addicted to licit drugs, but, at the same time, they are represented as "victims" of a national "epidemic."

More than highlighting the appropriateness of therapeutic intervention, however, the loss of emotions also represents another threat to "proper" femininity. Historically, emotion has been perceived as a "feminine" domain and an essential part of feminine identity. Women are still expected to be emotive and are rewarded for expressing their emotions, even when women's emotionality is equated with vulnerability or weakness. Furthermore, "women have also been made to bear the brunt of 'emotional work' in society, both inside and outside the domestic sphere" (Illouz, *Oprah* 136). As Illouz notes, "women are more likely to pay attention to and monitor the emotional exchanges with their partners and children" (*Oprah* 254) as well as with others outside the domestic sphere. "The control and reflexive management of emotions have become intrinsic to women's identity" (Illouz, *Oprah* 136). Thus, the loss of emotion via drug addiction represents a threat to femininity.

Michele must go on, therefore, to display her emotions, which she does as she describes how she handles her drug "cravings." She reminds herself that she has "made a choice" to stop using, that she has "so much to lose," and that her ex-husband and son support her endlessly. "Every single time I crave that drug," Michele explains, "I focus on those two." The camera pans to her ex-husband and her son, who are sitting in the front row, and then to Debra Jay, who raises an apprehensive eyebrow.

Invited by Winfrey to speak, Jay expresses her concern over Michele's approach to recovery:

> Right now what's going on with you is what we call white-knuckle sobriety, OK? Every day you're just hanging on for another day but you don't have recovery. Not using a drug is not recovery. . . .It's just a gateway to recovery. It just gives you the right to belong to the group. . . . And you have the support system of family and friends. But they cannot give you everything you need. . . .You need other recovering women in your life. I would love you to make a commitment. And you told me one thing you really want to do is work and help other women.[14] . . . And that's would you could do, and that's how you'll stay sober.

Jay's distinction between not using and recovery reminds us that recovery is an elaborate institution whose protocols engage "the concept of the 'free individual' as author and agent of her actions and destiny" (Peck, "Mediated Talking Cure" 142) in paradoxical ways. Michele's *choice* not to use methamphetamine, an assertion of her will as a "free individual," is not a valid or viable recovery strategy, according to Jay. Yet, recovery, and therapeutic discourse generally, construct the self as the site of the solution to addiction (Peck, "Mediated Talking Cure" 142). In other words, the onus is on the individual to "cure" and discipline herself, but, paradoxically, she cannot do this without therapeutic intervention and/or a therapeutic community.

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[14] This comment seems to allude to an off-air conversation.

The therapeutic community that Jay prescribes is unsurprisingly "other recovering women." In Jay's configuration, Michele simultaneously occupies two positions in the hierarchy implicit in such a community. On the one hand, she barely has the "right to belong to the group." On the other hand, Jay deems Michele able to help other women. Her experience of addiction and her 42 days "clean" make her an "expert," as all recovering addicts are within the discourse of recovery (Miller 105). In Jay's formulation, helping other women will constitute Michele's recovery. I do not want to suggest that being among other recovering women would not contribute to ending Michele's suffering, or that there is absolutely no potential for women to reconfigure their addictions in social rather than individual terms within these groups. For white, middle-class women, however, recovery's focus on the retrieval and recuperation of concealed core is most often the equivalent of recuperating and reestablishing normative femininity. As Melissa Pearl Friedling suggests, and as we saw in both Lydon's and Morrison's experiences of recovery, "curative models of female agency in recovery reaffirm a normal or essential female situation that may be reclaimed through the pacifying rituals, disciplinary practices, and self-directed criticisms entailed in a *cure*" (5). Michele's story ends neatly with her shaking Jay's hand to seal her "commitment" to helping other women and, therefore, to helping herself recover (17).

Conclusions

"Emotion Talk"

Each of the women evoke emotion in some way in their stories of addiction. After treatment, Chantel cites the suppression of painful feelings as a reason for taking methamphetamine. On the drug, she tells Winfrey, she can ignore the sadness she experiences when she thinks about her family. In recovery, Chantel must learn to control her anger. With Sara, Winfrey raises the issue of what she calls numbed emotion and Sara admits that recovery meant "facing" emotions that the drug had allowed her to "numb" for years. Sara too learns to "open up" and "deal with" her emotions in recovery. Michele discusses the loss of emotion not as a desired outcome of her drug use, or as a reason for taking methamphetamine in the first place, but as a devastating consequence of it. The drug's ability to "take away all your emotions" transforms Michele into a neglectful mother and a bad wife. Her recovery consists not only of recovering those lost emotions, but of publicly displaying them.

It is tempting to criticize what Illouz calls "emotion talk" as "emotional determinism," as a mechanism by which social problems are reconfigured as individual psychological problems, which, in turn, are understood as pathological problems that bring an unsettlingly significant portion of the population under the disciplinary management of medicine and its various therapeutic regimes. This criticism, albeit legitimate, simply does not account for why emotion is so prevalent at this moment as a way of making sense of troubling individual as well as collective behaviour such as addiction.

Illouz contends that "emotions are the ways in which the problematic relation between self and others is discussed in contemporary American discourse in general and in talk shows in particular" ("'That Shadowy Realm'" 117). "Emotion talk," she argues,

> is almost always a way to talk about oneself in the framework of an embattled relation in which the integrity of the self is threatened. . . . *[E]motion talk is talk about social relations*, that is, talk about the simultaneous importance of intimate relations and the elusiveness of norms that should ground such relations. . . . Thus in talk shows, and perhaps in American culture at large [and, I would add, in the discourse of addiction and recovery], emotions are ways to talk about (broken or longed for) social solidarity. (Italics in original; "'That Shadowy Realm'" 118-19)

Illouz goes on to contextualize the centrality of emotion on *Oprah* by explaining the broader cultural centrality of intimacy as a paradoxical function of the dissolution of normative guidelines on which individuals can rely to resolve personal and moral disputes (120). Her sharp and succinct explanation is worth quoting at length; it elucidates not only the dynamics of *Oprah*, but also the primacy of emotion in contemporary addiction and recovery discourses as well as the larger cultural conditions of both. Illouz writes:

> The centrality of emotion and conflict in Winfrey's (and others) talk show is thus to be understood against the backdrop of the centrality of intimacy has taken in the constitution of modern identity and in the context of the deeply embattled structure of everyday life in which no moral language is readily available to discuss the embattled self. When social relations cannot be discussed by leaning on moral prescriptions, then emotions become the only cultural category through which these relations can be discussed. Talk

> shows' obsession with emotions stems from the quasi-impossibility in which American culture is to discuss moral issues other than in subjectivist and emotional terms. . . When the normative ground of relations has become flimsy, the only thing we can rely on with clarity and certainty is our emotions. If there is no a priori way to adjudicate between conflicting points of view and moralities, then emotions become the only sure way to talk about broken commitments and longed for social solidarity. ("'That Shadowy Realm'" 120)

Illouz's account of "emotion talk" complements contemporary psychosocial theories of addiction, where addiction is understood an adaptive response to the material and psychological dislocation produced by the dissolution of social institutions under late capitalism. These theories, which I outline in my Introduction, also point to a loss of the "normative ground of relations" and a self whose integrity is threatened by capitalism's alienating effects. For these cultural theorists, addiction is a substitutive relation (Forbes 15-16).

But "emotion talk," as we have seen, is also prevalent within the popular discourse of addiction and recovery itself. For as much as we hear about addiction as a "disease," as a medical condition, or as a mechanism of unfortunate genetics and faulty neurobiological processes, emotion figures prominently as an etiological script. On the one hand, the centrality of emotion in theories of drug addiction is nothing new. Since the beginning of the twentieth century, physicians and psychiatrists have remarked on the psychologically anesthetizing effect of drug use and addiction. To recall my introductory epigraph, Charles Terry wrote in 1921 that "the psychology of the addict . . . is the psychology of you and me when in pain, of you and me when desiring relief. . . It is the psychology of self-defense, of self-protection, and it is the psychology arising from persecution, intolerance and ignorance" (41). Drug addiction has long been understood as a way to cope with unbearable psychic pain and overwhelming emotions. Correspondingly, negative emotions have figured prominently in institutional, especially psychological, as well as personal causal narratives of drug addiction.

On the other hand, emotion has never been quite as central to the concept of addiction generally and to recovery from drug addiction more specifically as it is at this moment. The "new" addictions – sex addiction, codependency, compulsive shopping, for example – are theorized as "addictions of the emotion" (Furedi 121). As opposed to earlier addictions, including drug addiction and alcoholism, which revolved more transparently around the notion of "physical dependence," these so-called addictions represent disordered, often "excessive" emotion,[15] which is often understood as the consequence of a history of emotional pain.

To complicate matters further, such "emotional determinism" is not wholly divorced from the concept of "physical dependency." Increasingly, neuroscience encourages us to understand emotions as physiological processes and disorders that can be tangibly controlled through medication. Emotions are more frequently described as distinct neurochemical reactions to which we (can) become habituated. Still, even as many of the "addictions of the emotion" are increasingly treated with anti-depressant and anti-psychotic drugs, and even as the treatment of these "new" addictions affects the conceptualization of drug addiction as an "emotional problem," or as a mechanism of disordered emotions, recovery, particularly from drug addiction, demands a less tangible course; the drug addict must acknowledge, assess, and "authentically" engage with painful feelings from her past as well as with the resultant shame and guilt of being "a drug addict." And historically, as I have suggested, "emotional problems" and such curative engagement with emotion have disproportionately affected women and have been regarded as distinctly "feminine."

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[15] Nonetheless, these "addictions of the emotion" have medical, psychiatric labels that lend authority to the notion that individuals are powerless over their emotions and their subsequent behaviours.

Pathologizing "Normal" and Normalizing "Pathology"

Oprah's guests' stories of pain and, more specifically, addiction at once represent "normal," everyday experiences and a deviation from norms. This contradiction is also a generic convention of *Oprah* and a characteristic of addiction in its most contemporary conceptualizations: both *Oprah* and addiction revolve around the "violation of a norm – legal, moral, or pertaining to the integrity of the ['healthy'] self" (Illouz, *Oprah* 86); but both rely on the presumption that such deviation is the normal condition of Western culture.

In my Introduction I describe the apparent limitless circumference of addiction attribution (Sedgwick 133) and the resultant ubiquity of addiction as the defining characteristics of addiction in its current conceptualization. I suggest that this "epidemic addiction," to borrow a phrase from Sedgwick, can be understood as part of a broader cultural shift in which a vast array of heretofore "normal" behaviours and emotions have been pathologized, systematically treated as illnesses that require medical or otherwise therapeutic intervention. Addiction both reflects and extends this pathologization and reinforces what I see as a consequential normalization of pathology. I also suggest that the contemporary white, middle-class female addict embodies this apparent paradox: her pathology – her addiction – is highlighted by her "normality," but addiction and pathology are "normal" conditions of not only contemporary Western culture, but also, more conventionally, of femininity.

When I began watching addicted women on *Oprah*, I was alarmed by how normal the show made addiction and addicts appear, even though I recognized that this normalization is in keeping with contemporary representations of addiction as a "normal problem of existence that afflicts every section of society" (Furedi 123). I initially imagined an argument that would problematize *Oprah*'s normalization of addiction among white, middle-class women. To render such a previously stigmatized behaviour "normal" while it retains its urgency and life-threatening danger and simultaneously acquires the status of a disease that necessitates medical intervention seemed troubling, particularly for women who embody normality but have nonetheless been historically subject to pathologization. Such normalization of addiction also seemed to me like a convenient sidestep: when addiction and pathology are "normal," the need to ask what socioeconomic and cultural conditions contribute to them is significantly diminished.

Delineating the generic conventions of *Oprah*, Illouz offers another way to understand the apparent paradox that these women embody as simultaneously normal and deviant and/or pathological. Illouz suggests that Winfrey "systematically queers" everyday life, particularly the "realm of domesticity" (*Oprah* 66), which, of course, is traditionally women's realm. By "queering," Illouz means that Winfrey "renders normal what is constructed as marginal and threatening to the middle-class ethos" and, vice versa, that she renders what is constructed as "normal – conventional domesticity – foreign and strange" (*Oprah* 67). Thus, Winfrey presents her guests in a way that "clearly plays on the contrast between middle-class respectability and an underground deviant identity" (*Oprah* 67). As Illouz states:

> it is the fact that [Oprah's guests] simultaneously display attributes of conventionality and marginality that makes them interesting. Oprah determines the representation of respectability and normality by showing us that the normal and the destitute [or the deviant] overlap and substitute for each other. . . .Oprah's technique consists of a systematic undermining of ordinary representation of both normality and deviance. (*Oprah* 68)

According to Illouz, "by aggrandizing daily life in its most trivial aspects and simultaneously defamilarizing it, [Oprah] is able to show the arbitrary character of its normative underpinnings. The deviant is made normal and the everyday is made to look unfamiliar" (*Oprah* 70). *Oprah* thus engages us "in a debate about the contextual validity of the norms and values we hold" through the public discussion of the reasons why people behave "immorally" or "abnormally" (Illouz, *Oprah* 74). The overall effect, Illouz suggests, is that "we cannot assign a fixed moral meaning to these characters" (*Oprah* 73). Ironically, however, "the show's endless staging of the fact that no norm can be taken for granted is what makes it into a moral genre that foregrounds reflexively the normative and moral underpinnings of our actions" (Illouz, *Oprah* 74).

Illouz's analysis elucidates the paradox of drug-addicted women as at once "normal" and "deviant." Addicted women on *Oprah* are compelling precisely because they are presented as simultaneously conventional and marginal. The popular discourse of drug addiction, which draws on a century-long history of stigma and demonization as much as it reflects a contemporary prevalence of a therapeutic ethos, adds another contradictory layer to *Oprah*'s "systematic queering," however. Although the discourse of drug addiction in contemporary therapeutic culture contains comparable ambivalence, *Oprah* does not necessarily "queer" dominant ideas about drug use and addiction. In fact, Winfrey, the "experts," and the guests often reproduce some of the most propagandistic "war-on-drugs" rhetoric at the same time as they draw on remarkably oversimplified, mainstreamed medical concepts often to justify involuntary institutional intervention. While *Oprah*'s queering makes it difficult for the audience to, as Illouz says, fix "moral meaning to these characters," (Oprah 73), longstanding connotations of the drug addict as morally corrupt, inherently deviant, and sociopathic, for example, make it somewhat easier to attach "moral meaning" to the addicted guests. On the other hand, drug addiction filtered through *Oprah*'s therapeutic imperative becomes more of a condition of everyday life, an emotional and physical illness that regularly overtakes even the most "normal" people. Using therapeutic language and concepts of drug addiction as a "normal" pathology, *Oprah* does "queer" the figure of the white, middle-class female addict. *Oprah*'s addicted guests and the audience are left to navigate the multiple contradictions of these intertwined discourses.

The centrality of autobiographical storytelling on *Oprah* illustrates a phenomenon that I refer to in my Introduction as the cultural presence of the white, middle-class female drug addict as a marketable commodity. More specifically, in the case of *Oprah*, the commodification of autobiography transforms the white, middle-class female drug addict into a commodity. In her mapping of the talk show as a genre, Illouz argues that talk shows differ from the rest of commercial television

> because they transform the participants' own life stories and biographies into commodities and circulate them in global markets. . . .[Talk shows] do not publicize or advertise a commodity already circulating on the market.[16] Instead, they create commodities – a biographical story converted into TV time sold to advertisers – from the raw material of participants' stories of pain, deprivation, and conflict. (*Oprah* 58)

Publishers also transform life stories into commodities, and, as the "memoir boom" of the 1990s illustrates, stories of pain, illness and personal conflict certainly sell (Gilmore). However, in converting personal, life stories into commodities, Illouz adds:

> talk shows represent the ultimate penetration of global capitalism into the innermost fabric of our lives.
>
> These created commodities are unpaid for and represent a surplus value. . . . Life stories are collected and traded for the guests' ephemeral appearance in the public sphere, but this appearance has no economic

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[16] Of course, *Oprah* also publicizes commodities that are already circulating on the market. Oprah's Book Club and Winfrey's "Favorite Things" shows are obvious examples.

> returns, or symbolic value, for it ultimately returns to the non-remunerated realm of private life. (*Oprah* 58)

"This dynamic," she concludes, "points to a new face of global capitalism; it is not people's flesh, blood, and bones that are mobilized for the engine of capitalist profit, but their life stories and family secrets" (*Oprah* 58).

Reordering this relationship between talk shows and life stories as commodities, I would suggest that the white, middle-class female addict is marketable because she is culturally required to produce a life story and to circulate it publicly. Which is not to say that talk shows do not convert life stories into commodities; it is to say, instead, that in so doing, talk shows reflect the systematic public consumption of the female addict as a mechanism of her visibility and/or subjectivity. In other words, the commodification of this figure and of her life story governs her visibility, her cultural audibility, or the terms under which she is deemed legitimate and valuable.

Illouz's description of the commodification of biography is also important because it reminds us that *Oprah* functions within the capitalist system.[17] The life stories that *Oprah* commodifies must be contained within frameworks that do not threaten advertisers' "comfort factor" (Wells qtd. in Peck, "TV Talk Shows" 78). As Peck notes, "It is the task of the TV industry to create 'friendly' advertising environments, and to this end, it's also in the industry's interest to contain talk show topics within the arena of individual problems" (78). Like other television programs,

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[17] Winfrey has amassed a fortune based largely on the show's success. In 2004, Winfrey became the first African-American woman billionaire (Forbes.com). Winfrey appeared at #242 on Forbes' list of the 400 richest Americans in 2006 with a net worth of $1.5 billion (Forbes.com).

Oprah aims to create profits for media owners via high ratings and advertising revenues, which means that it cannot make any critique that might challenge the interests of media owners, who are, of course, "an integral part of the capitalist class" (anonymous reviewer qtd. in Peck, "TV Talk Shows" 78). Given that contemporary theorists often link the pervasiveness of addiction to capitalism's alienating effects, we need to keep in mind *Oprah*'s profit motive as we interpret the stories the women tell about their lives as addicts. The show's profit motive arguably contradicts Winfrey's therapeutic ethos; while Winfrey claims to want to empower and help women through autobiographical storytelling, ratings are the show's ultimate goal, which are earned by trading on women's stories of pain.

A Personal and Political Epilogue

Over four years have passed since I wrote the "Personal Preface" that opens this dissertation. The somewhat indignant and defensive personal voice, whose admissions of routine drug use launched this project, now seems like a product of a different lifetime. The self that I describe in my opening pages, the self debilitated by depression and seeking solace in drugs, was, in some ways, exorcised in both the autobiographical and critical writing of this thesis. Thus, when my supervisor recently asked me if I might return to my personal preface and reincarnate its intimate tone in my concluding remarks, I resisted.

In fact, I am hesitant to include that preface in my dissertation. Foremost, I am concerned about how it might affect those who were closest to me during that time. I can imagine my parents, for instance, much like Martha Morrison's parents, uneasily explaining that they understood that I was under a lot of stress, but my grades were good, as far as they knew, and they couldn't imagine that I was in too much trouble. And, really, I wasn't "in trouble" in the way that lends itself to what Morrison calls "tales of addiction," "rather flamboyant stor[ies] replete with violence, crime, treachery, deceit, out-of-control sexual escapades [and] suicide attempts" (ix). I also have concerns about how the person to whom I refer in my preface as my "drug mentor" might receive my story. From time to time, memories of our relationship still smart, and I wonder if he could have known how deeply that pain motivated me, him, us. I can imagine him scoffing at such revelations.

Moreover, I still wonder what the implications of disclosing my drug use to a general readership and an academic audience might be. The irony of this concern is not lost on me; I have been writing about the implications of white, middle-class women's acts of self-disclosure and the effects of the cultural imperative for white, middle-class drug-using and addicted women to tell their life stories. I show that when these women reveal themselves as illicit drug users and addicts, they must also demonstrate adequate remorse, which overwhelmingly involves acknowledging that they have violated norms of femininity as drug users. Subsequently, dominant narratives of recovery from addiction grant women cultural redemption through the recuperation of "proper" femininity. Thus, heteronormative romance or reunion with a child and the commitment to become a "good" wife and mother often mark successful recovery for white, middle-class women. For women who are not imminently marriageable or maternal, such as Chantel, the teenaged subject of Oprah Winfrey's intervention show, noticeably conscientious attention to one's physical appearance often signals the mental and physical "health" of recovery.

My concern about the implications of my self-disclosure also raises questions about "personal criticism," defined basically as the practice of weaving self-narrative into critical argument (Miller, *Getting Personal* 2). To discuss the politics of "personal criticism" thoroughly at this point would be a digression; yet, as a scholar, I wonder if my autobiographical voice will be read as an outdated critical strategy or a clichéd example of the confessional mode. Perhaps I'll be seen as hypocritically "cashing in" on the contemporary cultural currency of women's personal stories and the visibility of the figure of the white, middle-class female drug addict. While I do not think that I have opened myself up to charges of "glamourizing" drugs, my autobiographical remarks are culturally permissible in part because white, middle-class women's stories of illicit drug use are a popular cultural commodity, as the stories of *Oprah*'s guests illustrate.

My "Personal Preface" was meant to illuminate the intertwined personal and academic motivations I had for pursuing a project about women's narratives of drug addiction, but writing in that personal voice and constructing a self-narrative also felt necessary to both my scholarly work and my private life at the time. Early in my research, I often felt that I was in conversation with the women whose lives I read. Although I hesitate to use the therapeutic language that so thoroughly suffuses women's contemporary narratives of addiction and recovery, reading these autobiographies and researching their historical, political, and discursive contexts was sometimes self-help-ish. I often caught myself in a kind of therapeutic pursuit, looking for answers to my personal suffering and finding them in critical reading and writing.

I wrote extensively, for example, about Elizabeth Wurtzel's representation of her regular illicit drug use in her bestselling memoir, *Prozac Nation: Young and Depressed in America*. I *read Prozac Nation* because it preceded Wurtzel's 2002 *More, Now, Again: A Memoir of Addiction*, which, at one point, I intended to use as a primary text. I envisioned a chapter that analyzed how Wurtzel perceived the relationship between her depression and her drug addiction. My intention was to foreground the fact that drug addiction does not occur unexpectedly or in isolation, although it is popularly treated as a distinct disorder. To my surprise, however, in *More, Now, Again*, Wurtzel repeatedly professes that she "didn't see addiction coming" (153). She makes no connection between her years of debilitating depression and her drug use, except to admit that "addiction got [her] what [she] needed" (153). She writes:

> Finally, people take my sorrow seriously. . . . Drugs put the fear of God into people the way a bad mood, even one that goes on for a decade, just does not. You can always wake up and feel better; that's always the hope with a depressive. But no one around me harbors that hope any longer. They are petrified. They are disgusted. At long last, my pain is a serious matter. (154)

From this passage, I constructed an argument about the differences between women's depression and drug addiction as cultural constructs, which became the basis of an article for a collection on depression narratives.

But before that, in a first draft of a chapter on Wurtzel's *Now, More, Again* as a reflection of the contemporary prevalence of the concept of addiction as a "brain disease" (Vastag 1299), I wrote about my contradictory attitude towards neurobiological theories. I had recently read an article in *Neuropsychopharmacology* entitled "Neurobiological Similarities in Depression and Drug Dependence: A Self-Medication Hypothesis." As the title suggests, the authors argue that "drug dependence and depression appear to be associated with alterations in some of the same neurotransmitter systems" (Markou et al. 135). I was intrigued by the discursive conflation that this neurobiological theory created between depression and addiction, especially given Wurtzel's remarks about people's discordant perceptions of her drug addiction and depression. I admitted:

> Despite my concerns that neurobiological explanations of depression and drug addiction negate socioeconomic and cultural factors, I find many of

> these theories convincing and enlightening. This response comes, at least in part, from my experiences with both depression and drug abuse. The idea that depression and drug dependence share certain neuromechanisms that appear to mediate specific core symptoms of both conditions has provided me with what I can only describe as a great sense of relief. This theory has given me a way to understand certain feelings and behaviours that, despite years of albeit intermittent therapy, were absolutely incomprehensible to me. Putting my drug-taking behaviours and depressive symptomatology in a neurobiological context has not absolved me of responsibility for my behaviour, as some critics of biological explanations of drug addiction foretell. Rather, it has relieved me of the guilt and shame of not being able to understand why certain situations and behaviours seemed forever beyond my cognition and control.

What strikes me now about this passage is its similarity to Martha Morrison's response to Dr. Talbott's lecture on the disease concept of addiction; recall Morrison's relief that "He had answers to some of the 'whys' that [she] had never understood" (184). Many women express relief upon receiving a medical diagnosis or learning and accepting a medical explanation of their addiction.[1] As I have shown, for white, middle-class addicted women, medical(ized) theories offer a kind of biographical script, a way to make sense of their lives that renders their voices culturally audible and valid. Moreover, popular medical discourse offers white, middle-class women institutional channels for recovery; of course, within this discourse, "recovery" is a process of self-reflection and individual transformation, void of any sense of the social and political factors of women's addiction. Furthermore, "recovery" is signaled not only by the cessation of drug use, but, more importantly, by the recuperation of heteronormativity and "proper" femininity. Yet, even as medicine and its prescribed route to recovery constitute a disciplinary regime for white, middle-class addicted women, their relief signals a relative privilege; unlike their lower-class, racially othered counterparts, these women have access to a legitmating discourse. My response to neurobiological explanations of drug dependence and depression reflects this paradigmatic paradox of medicalization.

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[1] For critical discussions of the healing power attributed to making sense of one's life through diagnosis, especially depression diagnoses, see Abigail Cheever's "Prozac Americans: Depression, Identity, and Selfhood," and Dwight Fee's "The Project of Pathology: Reflexivity and Depression in Elizabeth Wurtzel's *Prozac Nation*."

To the discomfort of my colleagues in my dissertation writing group, I wove a similar first-person voice throughout my chapter on Wurtzel's memoirs. In another instance, alongside Wurtzel's descriptions of her Ecstasy-induced reprieve from the isolation of depression, I wrote about the sense of community I felt when I was on Ecstasy. My colleagues suggested that I save these stories for a creative non-fiction forum. Initially, I resisted this advice. Part of what I liked about my autobiographical interspersions was that they occasionally challenged dominant discourses of illicit drug use and addiction. In fact, this is part of what I still like about my "Personal Preface." My assertion that "I felt like an intelligent, educated, and responsible drug-user" (vii), for example, reads like an oxymoron because of the stereotype of the drug user as out-of-control, reckless, and menacing. The suggestion that I consciously chose to use drugs, and used them very deliberately, contradicts the dominant discourse of illicit drug use, where "use" is invariably equated with "addiction" because illicit drugs are known as all-powerful and "instantly addictive." Ann Marlowe also challenges the cultural construct of "the drug's" absolute power and asserts her agency in the process (and discourse) of addiction in her 1999 memoir, *How To Stop Time: Heroin from A to Z*. Marlowe describes her addiction as "chosen" (144). "Most are," she writes: "Getting a habit isn't an accident, or the result of the 'power of the drug'; it's what you were after" (144).

How to Stop Time is a conspicuously rare counter-narrative to the stories of addiction and recovery that I read in this dissertation. Foremost, Marlowe is unapologetic about her heroin use. Unlike many women's narratives of addiction, Marlowe's memoir is not premised on the notion that her drug addiction is undesirably transgressive, or that, as an illicit drug user, she should seek redemption through the telling of her life story. Moreover, she rejects the determinism of the addiction concept. She writes, "There's something arbitrary about looking at my life and our times through the lens of heroin. I might have picked tennis, or shoes or cooking, all of which have been important to me for years and have their own cultural resonances" (280). Acknowledging the cultural potency of drug discourse, she continues, "But no. Every thread would not be equal. Our culture has lent dark powers to narratives of drug use, more than to drug use itself, and I am taking advantage of them, like a painter using the severity of northern light" (280).

Marlowe also refuses the conventional "narrative of inexorable decline and fatality" (Sedgwick 131) – the supposedly inevitable downward spiral that ends only after the addict hits the equally inevitable "rock bottom," and then, as Sedgwick writes, "leap[s] into that other, even more pathos-ridden narrative called *kicking the* *habit*" (131). Marlowe recognizes that contemporary North American culture invests exclusive authority in the "inexorable decline" narrative of addiction; dominant addiction and recovery discourses hold only certain experiences of drug use and addiction to be uncontestable knowledge, namely experiences that fit the downward trajectory, such as being fired from a job, alienating friends and family, and becoming physically incapacitated. Because Marlowe's experiences of addiction do not map neatly onto the conventional narrative of decline, and because she refuses to fit them into this conventional narrative as Twelve-Step rhetoric prescribes, earlier readers, she tells us, challenged her authority to write about addiction:

> When I published a cover story on heroin in the *Village Voice* in 1994, I got lots of nasty letters that all agreed on one thing: because I emerged from years of heroin use without noticeable health, career or financial effects, I wasn't qualified to write about dope. I didn't really have the experience, because the sign of really having the experience is ruining your life. This is a circular argument of course – "we only trust accounts of dope use that end in ruin, because dope use always ends in ruin." (153)

As I note in my preface, inquiries about my motivation for writing about women's drug addiction also raised questions about the relationship between experience and authority as it circulates in discourses of addiction and recovery. Although I would like to think that, like Marlowe, I offer a counter-narrative by showing that the habitual drug user is not inevitably "propelled into a narrative of inexorable decline and fatality" (Sedgwick 131), I've wondered too if my lack of material and psychological "ruin" nullifies my narrative of drug use or lessens my authority as a critic.

Furthermore, without "rock bottom" and ruin, "recovery" or therapeutic intervention is not necessary. As Elayne Rapping notes, the addiction treatment industry employs its own – addicts routinely become counselors (89). This economic function reflects the recovery industry's ideological investment in the notion that authority is born only of first-hand experience. Thus, not requiring institutional(ized) recovery, and/or refusing Twelve-Step rhetoric, as both Marlowe and I do, also diminishes one's authority to write about addiction. Marlowe stops using heroin on her own, which not only represents a negation of her authority within dominant discourses of addiction and recovery, but also contravenes the popularly held notion that, as *Oprah*'s addiction expert Debra Jay warns, it is impossible and dangerous to quit using drugs without expert, medical intervention. Marlowe theorizes, "What allowed me to quit and not do it again was giving up on the psychological pattern of need, rejecting the position of abjection" (230).

"Rejecting the position of abjection," however, is not imaginable for all women, even with the privileges afforded by middle-class status and whiteness. The narratives that I have analyzed in this project demonstrate how powerfully dominant discourses of addiction and recovery, especially as they intertwine with norms of white, middle-class femininity, shape subjectivity and construct what might appropriately be called positions of abjection. Recall the first step of Twevle-Step recovery: "We admitted we were powerless over [the drug(s)]." This notion of powerlessness perpetually circumscribes the recovering addict's understanding of herself. The idea that *the addict is always an addict* likewise produces an inexorably "diminished self" (Furedi 106), even when the addict's experiences are culturally validated by medicalized concepts of addiction. Furthermore, the subjectivity defined by contemporary dominant discourses of addiction and recovery is consistent with long-standing stereotypes of white, middle-class women as physically and psychologically weak, and dependent and helpless. Popular medicalized concepts of addiction as that which unexpectedly and blamelessly befalls vulnerable women also reinforces the concept of victimization as a norm of femininity. In other words, addiction in its contemporary conceptualization under therapeutic culture and dominant constructs of femininity complement each other insofar as they each construct a similarly fatalistic, diminished subject.

I am tempted to suggest that both Marlowe and I were able to "reject the position of abjection" because we had access to powerful discourses outside of the dominant discourses of addiction and femininity. Marlowe's story includes years of psychotherapy as well as graduate-level education in philosophy. My story obviously involves years of research and writing about women's drug use and addiction. And, as I have already implied, the tools of discourse analysis have allowed me to imagine alternatives to the typically diminished subjectivity of the female drug user. I am not suggesting that the majority of women whose stories I read in this project are cultural dupes who could have (and should have) cured their own addictions through critical thinking. I recognize my privilege both in having access to alternative discourses and in being able to make knowledge effective. Nonetheless, I am left with the question of how white, middle-class female drug addicts, who have relatively more privilege than their lower-class, racially othered counterparts, might also recognize and use their privilege to challenge the dominant discourse of addiction, which reinforces typically feminine passivity, powerlessness, and victimization at the same time as it represents addiction as a grave violation of femininity.

At the end of my analysis of Susan Gordon Lydon's use of trauma as a feminist framework for her narrative of addiction, I suggest that feminist theory can make the necessary link between the social and political conditions of women's experiences of trauma and addiction. As I have noted throughout this project, the tendency of contemporary discourses of addiction and recovery to shift our cultural attention to internal, emotional processes and individual culpability encourages us to overlook the complex socioeconomic and political factors of addiction. The late-twentieth- and early-twenty-first-century "epidemic of addiction attribution" (Sedgwick 131), under which compulsive behaviour has been normalized but nonetheless remains pathological, represents a depoliticization of addiction. Parallel to the feminist commitment to move the analysis of trauma "beyond an individual perspective to a larger sociopolitical, systemic framework" (Root, "Reconstructing 238), I suggest that feminist analyses of addiction should likewise highlight the interplay between sociopolitical factors and women's phenomenological experiences. Indeed, one of my goals has been to show how women's narratives of addiction negotiate this interplay even when the women engage individualistic, medicalized discourses to tell their stories.

While I have not sought to offer "cures" to women's addiction, and while I am not suggesting that a feminist approach to women's addiction is "curative," my analysis of women's narratives of addiction not surprisingly points to the necessity of social change, especially support for women's autonomy (Campbell 223). In his 1976 book, *Love and Addiction*, Stanton Peele poignantly asserts that

> The real cure for addiction lies in a social change which reorients our major institutions and types of experiences people have within them. . . . Just as we cannot begin to understand addiction without understanding people's relationship to their social setting, so we cannot begin to cure it in the absence of a more universal access to our society's resources and to its political power. (223-24)

Peele's call for a reorientation of our major institutions and more equitable distribution of resources and political power anticipates the contemporary sociological and psychosocial theories that I map in my introduction, which conceptualize addiction as an adaptive behaviour, a consequence of the dissolution of fulfilling social connections under consumer-oriented capitalism. Indeed, these turn-of-the-millennium psychosocial theories make an analogous call for social, structural change that would enable satisfying social connections and the construction of community. The addiction narratives that I examine in this project can be read as stories of mourning for the (often violent) loss or severing of social relationships. Likewise, I would suggest that the dominant discourses of addiction and recovery that these women use to narrativize their lives as addicts bespeak a powerful longing and search for community. Their narratives of addiction, in other words, attest to both the theory of addiction as a substitute for gratifying social connections (Alexander, "Empirical") and the necessity of reorienting our major institutions and "the types of experiences people have within them" (Peele 223). But how can this social change, this reorientation of our major institutions and redistribution of political power, happen? How can the kind of discursive analysis that I perform in this dissertation contribute to social change? And what might such an enterprise look like pedagogically?

As I come to the end of this project, I see the question of pedagogy as a primary area for my future research. The contemporary concept of addiction as a neurobiological, medical condition *and* a "common cultural signifier" (Forbes 16), or a new paradigm of subjectivity (Peele, "Cultural Construct"), necessitates interdisciplinarity. And the network of intertwined institutional definitions and discourses of drug addiction, which also includes discourses of gender, class, and race, requires a history. Fortunately, dissertation projects afford both the time and the space that such interdisciplinary research requires; my analysis of women's narratives of drug addiction reflects various medical, psychological, and sociological theories of addiction and draws on related interdisciplinary areas of study such as trauma, feminism, and cultural studies. But how does this methodology translate into pedagogy? Put simply, how would I teach this material?

Within the disciplinary boundaries of English Literature, I can imagine a course that focuses exclusively on women's published autobiographical accounts of their lives as illicit drug addicts. Even the small selection of texts that I examine here pose questions about how generic differences within life writing might affect the women's negotiation of discourses of addiction. How, for example, does Morrison's inclusion of doctors' reports influence her construction of her addiction? What is the impact of O.W.'s diaries? Or, more specifically, why did the publishers seem to assume that the diaries would establish credibility? As I mention in a footnote in Chapter 1, Janet Clark's *The Fantastic Lodge* is a transcription of recordings that she made during the mid-to-late 1950s with an acquaintance, budding sociologist Howard Becker; is the influence of Becker's ethnographic research and sociology's then-nascent foray into addiction felt in Clark's story? Ann Marlowe's *How to Stop Time* is organized as a glossary; instead of chronological chapters, she has over a hundred brief, alphabetically organized essays on keywords related to her life and addiction; how does this arguably postmodern narrative strategy reflect her interpretation of addiction? Furthermore, all of the women whose stories I've read experience institutional encounters where they are required to produce an autobiographical narrative. That is, in courtrooms, at police stations, during patient in-take interviews, for example, they face an external imperative to construct a kind of autobiography; how do such institutionally-determined and public autobiographies function within their extended life stories? Additionally, many women, including O.W., Morrison, and Lydon, describe the act of writing as therapeutic; how do we theorize autobiography as a therapeutic act, especially for women who have long been associated with "private" types of writing?

This last question might also form the basis of a course in Medical Humanities. Perhaps maintaining a focus on gender, the course could compare women's and men's autobiographical narratives of addiction and recovery; do these writings suggest a discernable difference in the way men and women understand themselves as addicts? Might these narratives help treatment professionals and/or medical researchers shape treatment options, particularly if the act of writing itself is understood as therapeutic? How might memoirs of drug addiction influence medicine's interpretation of addiction?

Under the rubric of Cultural Studies, I can envision a course on the figure of the drug-addicted woman in popular culture. The female drug addict has a century-long presence in popular visual texts such as advertisements and film. As a part of my early attempts to untangle the paradoxical characteristics of the white, middle-class female drug addict – specifically the desirability and glamour of her abjectness – I examined Christian Dior's 2003 advertising campaign for their perfume, *Addict*. The *Addict* ads feature a thin, wet, and goose-fleshed woman (model Liberty Ross), barely clad in a dark bra and underwear against a backdrop of dark purple, blue, and red urgent, urban lights; her shoulders are hunched, her head is thrown back, and her facial expression connotes a pleasurable pain. Across her chest, she wears the name brand and label, "Addict," while the tag line at the bottom of the ad invites us to "Admit It." I interpret the *Addict* ads as a startling example of the stylization and commodification of the female drug addict. A Cultural Studies course might focus on this commodification and the construct of women as both the performers and intended consumers of addiction. Fashion is a popular location for the figure of the female addict, as the mid-1990s trend of "heroin chic" also attests. But, as I suggest in my last chapter, *The Oprah Winfrey Show* is also a site of such commodification; women's personal stories of addiction perform part of the stylization of addiction on *Oprah* and constitute one aspect of this commodified figure. White, middle- and upper-class addicted and recovering women also populate popular TV dramas and contemporary Hollywood films. Drawing on theories of popular culture and commodity, and feminist theories of women as consumers and the consumed, as well as popular theories of addiction, this course would examine the implications of the marketability of the figure of the female drug addict.

These courses would also open my research up to writers and representations of different ethnicities and classes. I can imagine including Maggie de Vries' *Missing Sarah: A Vancouver Woman Remembers Her Vanished Sister* (2003) and Maria Campbell's *Half-Breed* (1973), for example, in a course on women's autobiographical narratives of drug addiction. In fact, these books, which depict ethnically and economically marginalized women's experiences of drug addiction, would work towards creating a more balanced and more explicitly politicized picture of addiction among women. Sarah de Vries, one of the many women who have, as the mainstream media is fond of saying, "disappeared" from Vancouver's downtown eastside, is not subject to the medicalized discourse of addiction and its privileges of recovery and cultural redemption. While Maggie de Vries' account of Sarah's life attempts to counter punitive and stigmatizing notions of addicted women by showing Sarah as creative and caring but traumatized and troubled, Sarah and Vancouver's many other "Missing Women" are not seen as "redeemable" or even worthy of the social resources that might help them. While published life writing by disenfranchised female addicts is far rarer than life writing by white, middle-class addicted women, the accounts that do exist could productively be read alongside narratives that rely on medical discourse for cultural audibility and authority.

Pedagogically, narratives of disenfranchised female addicts also more obviously represent venues to effect social change. That is, I suspect students would understand addiction more clearly as a social and political issue via the stories of disenfranchised addicts than they would via *Oprah*'s guests stories, for example, where addiction is a normal condition of everyday middle-class life.

Correspondingly, I expect that students would imagine political solutions to addiction among disenfranchised women more easily than they could imagine systemic change that would affect white, middle-class female addicts. I realize that this formulation presents a set of complex problems, including the risk of reinforcing the stereotype of the female drug addict as "an exploited, degraded victim . . . ready to sell her body for the price of her next dose" (Palmer and Horowitz 11), as well as reinforcing the (most likely) middle-class privilege of the student and "the belief that one's own culture and morality are . . . universally applicable" (Keller, Nelson, Wick 45). Nonetheless, I would like to use narratives of both marginalized and relatively privileged addicted women to pursue a pedagogy that actively promotes social transformation.

I'm particularly interested in Community Service-Learning (CSL) as a pedagogy that complements the interdisciplinary study of addiction, specifically addiction among women. The Canadian Association of Community Service-Learning defines community service-learning as "an educational approach that integrates service in the community with intentional learning activities." In other words, students volunteer with a local, not-for-profit community organization as part of a university course. One of the basic suppositions of service learning is that it "increases students' understanding of the community as well as their sense of civic and social responsibility" (Hutchinson 428). As Mary Trigg and Barbara Balliet explain in their article, "Learning Across Boundaries: Women's Studies, Praxis, and Community Service," "Advocates of service-learning hope it will contribute to creating new generations of students who understand the way government [and other political and social institutions work], and who will feel and act on their sense of responsibility to their communities" (87). Ideally, service-learning promotes social change by understanding power distribution (Chin 57). More realistically, service-learning can offer an insightful starting point to discuss the power differentials of class, race, gender, ability, and sexual orientation (Camacho 32).

Given contemporary sociological and psychosocial theories of addiction that cite the loss of community and "dislocation" as the "precursor of addiction" (Alexander, "Globalization" 502), Community Service-Learning, with its emphasis on community experience and strengthening communities, provides an intriguing framework for studying addiction. What if students, working in (ideally) reciprocal relationships with addicts and recovering addicts and their not-for-profit service providers, could help create "healthy communities"? Advocating social responsibility, Community Service-Learning similarly has the potential to address what Furedi calls "the decline of an ethos of public responsibility" (72), which the contemporary addiction concept exemplifies. Working with various populations affected by drug addiction would hopefully challenge students to question individualistic explanations of addiction. Students are often confronted with their own privilege in service-learning courses both in service placements and in the classroom; how might the recognition of one's relative privilege contribute to or challenge the discourse of white, middle-class women's addiction under therapeutic culture? In a Community Service-Learning course that focuses on women's drug addiction students would engage with and negotiate the discourses of addiction experientially. These are the experiences that have the potential to produce new cultural as well as personal narratives of drug addiction, narratives that repoliticize addiction by making the necessary links between the social and political conditions of women's lives and their addiction.

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